STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G032	A. BUILDING _____ B. WING _____	05/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY ICF/MR GROUP HOME	115 STORYBOOK LANE SYLVA, NC 28779

(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 an emergency preparedness plan (EP) that identified and addressed the specific needs of 5 of 5 clients residing in the group home. The finding is: Review of the facility's EP, conducted on 5/8/18,	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 revealed the EP contained a thorough risk assessment and community-based strategies including a face sheet and physician's orders for medications for each client residing in the home. However, further review of the facility's EP, verified by interview with the qualified intellectual disabilities professional, revealed no additional specific client information was included in the EP to direct any volunteers or those unfamiliar with the clients in the group home in how to assist the clients in case of an evacuation or disaster identified in the EP.	E 006		
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: Based on observation, record review and interviews, the facility failed to assure techniques to manage inappropriate client behavior were not used as a substitute for an active treatment program for 1 of 3 sampled clients (#2). The finding is: Observations conducted in the group home on 5/8/18 at 9:15 AM revealed client #2 was sitting in a recliner in the living room of the home while the other clients residing in the home were were assisted by staff to load onto the facility's van for transportation to the day program. Staff was then observed to prompt client #2 that it was time to load onto the van and go to the day program. Client #2 was then observed to loudly and	W 288		

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W 288	Continued From page 2 emphatically vocalize "no". Continued observations revealed staff prompted client #2 several more times that it was time to get onto the van, with client #2 continuing to state "no' each time. Further observations at 9:20 AM revealed two staff approached client #2 as she sat in the recliner and transferred her into a wheelchair, transporting her to the van as she continued to state "no". Client #2 was then assisted by staff to load onto the van. Review of the record for client #2, conducted on 5/8/18, revealed an Individual Habilitation Plan dated 6/8/17 which included a behavior support plan (BSP) dated 8/18/16. Continued review of the 8/18/16 BSP for client #2 revealed target behaviors were identified as aggression, property misuse, and disruptive behavior defined as: making false allegations, yell, curse, verbal threats and threats to harm others. Further review of the BSP revealed a wheel chair was to be utilized for client #2 only when staff observed client #2's mood to negatively effect her mobility in a severe manner at which time the group home manager/qualified intellectual disabilities professional (QIDP) should be consulted about using a wheelchair temporarily. Interview with the group home manager on 5/8/18 at 9:20 AM revealed client #2 often refuses to load onto the van in the mornings, and is taken by wheelchair to the van and assisted by staff to load onto the van when that occurs. Interview on 5/8/18 with the QIDP verified client #2's current BSP does not address refusals or non-compliance as targeted behaviors. Continued interview with the QIDP revealed client #2's BSP should be followed as prescribed.	W 288		