STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G132	A. BUILDING _____ B. WING _____	05/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTY WOODS GROUP HOME	10100 MT. OLIVE ROAD MOUNT PLEASANT, NC 28124

(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 interview and record review, the facility failed to develop specific facility-based strategies as part of their emergency plan. The finding is: The facility failed to develop a thorough risk assessment based on the clients specific needs to include in their Emergency Management Plan	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	E 006		

(EMP).

Review on 5/7/18 of the EMP revealed this plan was written in a general way to accommodate the needs for the facility. Continued review of the EMP and interview with the qualified Intellectual disabilities professional (QIDP) revealed facility-based information needed to be developed to address the specific needs of the clients in the group home. For example:

A. Review on 5/7/18 of the EMP revealed one of the highest potential emergency disasters facing the group home was identified as tornadoes and winter storms. Review of the EMP tornado and winter storm plan revealed a general information sheet regarding what to do in case of a tornado, winter storm or loss of power.

B. Review on 5/7/18 of the EMP also revealed one of the highest potential emergencies to include a severe power outage. Observations in the home, substantiated by interview with the QIDP revealed a lack of supplies such as lights or emergency radios in the home as part of the specific plan to deal with a severe power outage in the group home. In addition, there was no information relating to what emergency resources would be available in that community or how staff could access emergency personnel.

C. Review on 5/7/18 of the EMP revealed information regarding the residents of the group home was limited to the general information contained on an information face sheet. Further review of the EP and interview with the facility administrator revealed no information regarding the specific needs of the 5 residents of the group home to assist anyone unfamiliar with the

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E 006	Continued From page 2 residents working with them in an emergency situation.	E 006		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an 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 staff interview, the facility failed to develop a plan for alternate communication with facility staff and guardians for clients should phones become inoperable in an emergency. The finding is: The facility failed to develop an alternate plan for communication between direct care staff and outside community resources in the event of a primary communication failure. Review on 5/7/18 of the facility's emergency management plan (EMP) revealed this plan included strategies for staff to use primary phone and cellular phones to communicate with each	E 032		

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E 032	Continued From page 3 other in the event of an emergency. Interview on 5/8/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed there was not an alternate plan for communication between staff and management of the facility in the event primary phones or cellphones were inoperable. Further interview revealed there was also no alternate plan for staff to communicate with emergency management officials in Cabarrus county.	E 032		
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: Based on record review and interview, the facility failed to assure both guardians were able to be reached if needed. The finding is: Client #1's legal co-guardians were not able to be reached for consent as needed. Review on 5/8/18 of client #1's individual program plan (IPP) dated 6/16/17 revealed she has co-guardians. Interview with management on 5/8/18 revealed the facility is not able to reach one of the two legal co-guardians for client #1. She further indicated she did not know the facility should pursue removal of the guardian who cannot be reached. She acknowledged that only one guardian signs	W 125		

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W 125	Continued From page 4 facility consents and was not aware both guardians had to sign consents.	W 125		
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 interviews, the facility failed to ensure 2 of 3 audit clients (#1, #4) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of following prescribed diets and mealtime procedures. The findings include: 1. Staff failed to provide client #4 with her physician prescribed diets at all meals observed. During lunch mealtime observations on 5/7/18 at 11:40am client #4 was given a plate with a meat sandwich roll up with whole pieces of meat and cheese inside of a roll up that was cut into half. She also had chips, 2 cups with tea and water. During breakfast observations on 5/7/18 at 7:25am client #4 had cheese toast cut into half inch pieces, oatmeal with raisins. Client #4 ate	W 249		

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W 249	Continued From page 5	W 249		

several pieces of cheese toast wedged together in about inch size pieces. Staff at the table did not redirect her to cut these pieces into smaller pieces.

Review on 5/8/18 of client #4's individual program plan (IPP) dated 1/12/18 revealed her diet was 1500 calorie diet with no seconds with up to 6 tablespoons of Benefiber.

Review on 5/8/18 of client #4's feeding guidelines dated 2/20/13 revealed "bite sized pieces, sandwiches quartered, finger food whole, meats finely chopped."

Interview on 5/8/18 with the qualified intellectual disabilities professional (QIDP) revealed client #4's sandwiches, including the roll ups, should be quartered, all meats should be finely chopped and all food should not exceed small bite sized pieces not larger than a quarter.

2. Client #1's oral motor program was not consistently implemented as written.

During observations on 5/7 and 5/8/18, staff were observed to implement aspects of the oral motor program prior to meals. Staff at both meals rubbed the probe to her upper lip and lower lip and circled inside her mouth. However staff did not do this five times at either lunch or dinner. At breakfast, it was completely forgotten so the oral motor program was not completed. Tapping the tongue and getting the client to chew on the probe ten times was not observed at all.

Review on 5/8/18 of client #1's IPP dated 6/16/17 revealed the oral motor program implemented 2/8/18. This program included using an oral probe to rub her upper lip for five seconds, lower

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W 249	Continued From page 6 lip for five seconds, inside of upper lip for five seconds, inside of lower lip for five seconds, circle inside her mouth from cheek to cheek across both her tongue and roof of her mouth five times, tap the left side of her tongue five times and hold the probe against the inside of her cheek noting rather her tongue comes over to touch the probe, repeat on right side, press tooth on both the upper and lower jaw getting her to chew on probe 10 times. The plan noted these exercises can be done multiple times if desired. Interview on 5/8/18 confirmed the oral motor program was not implemented by staff at breakfast. Further interview revealed that the staff should implement each detail listed in the oral motor program when carrying this program out.	W 249		