STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G354	A. BUILDING _____ B. WING _____	05/01/2018

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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 observations, interview and record review, the facility failed to develop specific facility-based strategies relative to client information as part of their emergency plan. The finding is: Review of the facility's Emergency Program (EP)	E 006	The administrator will develop and implement, as a part of the emergency preparedness plan, a method to communicate the specific needs of each person in the home. The QIDP will train on the updated emergency plans inclusive of the specific needs of each person. The team will monitor to ensure staff's knowledge of the Emergency Plan monthly during house meetings. In the future, the administrator will ensure each Emergency Plan contains client specific information and staff are trained on the information. By: June 30, 2018 DHSR NH L & C Black Mountain WRO Received MAY 14 2018 by: SKH	6/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Carothers — TITLE: Facility Administrator — (X6) DATE: 5/9/18

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 to contain a thorough risk assessment and community-based strategies. However, further review of the EP revealed no method of communicating the specific needs of the clients in the group home. Observations in the group home, verified by interview with staff, revealed no method of communicating information regarding individual clients specific needs in case of an emergency. Interview with the administrator revealed no method had been developed and implemented as of the 4/30-5/1/18 survey to address communicating information regarding individual client's specific needs in case someone unfamiliar with their needs had to work with them in an emergency situation.	E 006		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the Person Centered Plan (PCP) for 1 of 3 sampled clients (#2) failed to include a recommended communication objective. The finding is: Observations conducted in the group home during the 4/30/18- 5/1/18 recertification survey revealed client #2 was essentially non-verbal. Continued observations revealed client #2 was	W 227	A team meeting will be held to discuss client #2's needs in communication training. The Habilitation Specialist will inservice staff on the results of the team meeting. The QIDP will revise Person Centered Plan (PCP) to include the team meeting. The clinical team will monitor through observations and interaction assessments 2 times a week for a period of one month, then on a routine basis to ensure staff are implementing client #2's communication program. By June	6/30/18

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W 227	Continued From page 2 verbally prompted by staff to do his laundry, eat meals, engage in leisure activities, take a shower and take his medications among other activities. Review of the record for client #2, conducted on 5/1/18, revealed a PCP dated 6/28/17 containing objectives for client #2 to brush his teeth thoroughly, dry his hands, wear his eyeglasses, identify coins, wash clothes, use a napkin, participate in physical activity and close doors for privacy. Continued review of the 6/28/17 PCP revealed a Communication Evaluation dated 6/1/17 documenting that client #2 understands 1-step verbal directions and requires accompanying visuals such as pictures to help process verbal information. Further review of the 6/1/17 Communication Evaluation revealed documentation stating client #2 should continue the use of the visual schedule and communication wallet put in place during his previous placement to indicate preferences, basic needs and describe feelings. Interview conducted on 5/1/18 with the QIDP revealed no formal objective had been put into place to address client #2's communication needs as recommended in the 6/1/17 Communication Evaluation. However, this interview verified client #2 does have a picture book in the home containing pictures that staff should utilize when prompting client to do laundry, eat meals, choose leisure activities and take medications among other activities.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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W 249	Continued From page 3 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 observation, record review and interview, the facility failed to assure prescribed interventions were implemented to support the achievement of goals listed in the Person Centered Plan (PCP) for 1 of 3 sampled clients (#2). The finding is: Observations conducted in the home during the 4/30/18-5/1/18 recertification survey revealed client #2 was not wearing eyeglasses at any time. The observations further revealed staff did not provide or prompt client #2 to utilize his eyeglasses. Review of the record for client #2, conducted on 5/1/18, revealed a PCP dated 6/28/17 which contained an ophthalmologic consultation dated 7/24/17 documenting eyeglasses were prescribed on that day for client #2. Continued review of the record for client #2 revealed a training objective implemented on 4/12/18 stating client #2 would wear his eyeglasses in the home for a 30 minute period with 90 % independence for 2 progress periods. This objective further stated staff should implement client #2's use of eyeglasses multiple times throughout his day in the group home. Interview conducted on 5/1/18 with the qualified intellectual disabilities professional (QIDP)	W 249	The QIDP will in-service staff on client #2 training objective to wear eye glasses. The clinical team will monitor through observations and Interaction Assessments 2 times a week for a period of one month then, on a routine basis to ensure staff are implementing client #2 program to wear eyeglasses as prescribed. In the future the QIDP will ensure staff are trained and implement clients training objectives as prescribed in the Person Centered Plan. By June 30, 2018	6/30/18

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W 249	Continued From page 4 revealed client #2's glasses were available in the home and further verified staff should provide the eyeglasses and prompt client #2 to wear them multiple times throughout the day.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: The team failed to ensure data was taken as prescribed for 3 of 6 skill acquisition objectives listed on the person centered plan (PCP) for 1 of 3 sampled clients (#5) as evidenced by interviews and review of records. The findings are: A. Review of the 10/23/17 PCP for client #5 revealed an objective to complete steps for administration of medication (Tegretol) with 90% independence with the objective implemented 4/16. Review of the objective data, verified by interviews with the qualified intellectual disabilities professional (QIDP), revealed no data was available for review for 9/17. Continued review of the records, verified by interview with the QIDP, revealed a data sheet had not been placed in the program book for data to be collected for 9/17. Therefore, no data was taken in 9/17. B. Review of the 10/23/17 PCP for client #5 revealed an objective to brush teeth thoroughly for 2 minutes with 95% independence with the objective implemented 4/17. Review of the	W 252	The Administrator will in-service the clinical team on the importance of making sure data collection sheets are implemented timely when objectives are implemented. The QIDP will in-service staff on data collection and documentation. The clinical team will monitor through observations 2 times a week for a period of one month then, on a routine basis to ensure data sheets are available and data collection is occurring as prescribed. The QIDP will monitor through Quarterly QIDP Reviews to ensure data sheets for prescribed objectives are available and data collection is occurring. In the future the QIDP will ensure data collection occurs as prescribed in the Person Centered Plan. By: June 30, 2018	6/30/18

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W 252	Continued From page 5 objective data, verified by interviews with the QIDP, revealed no data was available for review for 10/17. Continued review of the records, verified by interview with the QIDP, revealed a data sheet had not been placed in the program book for data to be collected for 10/17. Therefore, no data was taken in 10/17. C. Review of the 10/23/17 PCP for client #5 revealed an objective to read basic sight words with 90% accuracy with the objective implemented 8/17. Review of the objective data, verified by interviews with the QIDP, revealed no data was available for review for 9/17 or 10/17. Continued review of the records, verified by interview with the QIDP, revealed data sheets were not placed in the program book for data to be collected for 9/17 or 10/17. Therefore, no data was taken during 9/17 or 10/17.	W 252		
W 256	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(ii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. This STANDARD is not met as evidenced by: The team failed to ensure 3 of 5 skill acquisition objectives listed on the person centered plan (PCP) for 1 of 3 sampled clients (#4) were revised when regression occurred as evidenced by interview and review of records. The findings are: A. Review of the 3/30/18 PCP for client #4	W 256	A Team Meeting will be held for Client # 4 to review training objectives and need for revisions. The Habilitation Specialist will train staff on the results of the Team Meeting. The QIDP will revise the Person Centered Plan to reflect the changes. The clinical team will monitor during quarterly Chart Reviews to ensure program revision occurs as needed. The QIDP will monitor through Quarterly QIDP notes to ensure revisions occurred as needed.	6/30/18

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W 256	Continued From page 6 revealed an objective to complete process of sweeping with 95% independence with the objective being implemented 1/5/17. Review of the objective data revealed the client was functioning at the 97% level in 8/17. Further review of the data revealed the client to function at 89% in 9/17, 82% in 10/17, 86% in 11/17, 81% in 12/17, 84% in 1/18, 70% in 2/18 and 78% in 3/18. This is a decline of 19 % after 7 months of training. Further review of the objective, verified by interview with the qualified intellectual disabilities professional (QIDP), revealed no revisions had been made to address the regression of skill level. B. Review of the 3/30/18 PCP for client #4 revealed an objective to participate in leisure activity with 95% independence with the objective being implemented 1/5/17. Review of the objective data revealed the client was functioning at the 98% level in 9/17. Further review of the data revealed the client to function at 94% in 10/17, 52% in 11/17, 91% in 12/17, 86% in 1/18, 68% in 2/18 and 80% in 3/18. This is a decline of 14 % after 6 months of training. Further review of the objective, verified by interview with the QIDP, revealed no revisions had been made to address the regression of skill level. C. Review of the 3/30/18 PCP for client #4 revealed an objective to exercise an average of 30 minutes per day with 95% independence with the objective being implemented 1/5/17. Review of the objective data revealed the client was functioning at the 65% level in 9/17. Further review of the data revealed the client to function at 57% in 10/17, no data was available for 11/17 or 12/17. She was at the 36% level in 1/18, 48% in 2/18 and 52% in 3/18. This is a decline of 13%	W 256	Continued: In the future the QIDP will ensure the Person Centered Plan is revised when regression or completion of training objectives occurs. By: June 30, 2018	

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W 256	Continued From page 7 after 6 months of training. Further review of the objective, verified by interview with the QIDP, revealed no revisions had been made to address the regression of skill level.	W 256		
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: The facility failed to show evidence quarterly fire drills were conducted with each shift of personnel relative to 3rd shift as evidenced by interviews and review of records. The finding is: Review of the facility's fire drill records from 4/17 through 3/18 revealed 3rd shift fire drills were conducted on 5/2/17 and 12/20/17 only. Further review of the fire drill records, verified by interview with staff, revealed no fire drill records were present for review for 3rd shift from 5/17 through 12/17 or from 12/17 through 3/18. Therefore, the facility failed to show evidence 3rd shift fire drills were conducted on a quarterly basis with each shift of personnel.	W 440	The Administrator will in-service the Home Managers on the requirement for 3rd shift Fire Drills quarterly. The Administrator and Safety Chairperson will monitor all Fire Drills monthly to ensure they occur as required. In the future the Administrator will ensure staff are trained on requirement for Fire Drills and they occurred with each shift. By: June 30, 2018	6/30/18