STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G115	A. BUILDING _____ B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARTMOUTH ROAD GROUP HOME	210 DARTMOUTH ROAD RALEIGH, NC 27606

(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	E020 The noted deficiency will be corrected by the following actions: A. Staff will be trained on the Emergency Preparedness Policies and Procedures to include the Communication Plan, and Evacuation Procedures. The training will include staff responsibilities, care and treatment of evacuees, transportation, evacuation location, evacuation notification to guardians, and alternate means of communication should there be power failure. B. Home manager will conduct an evacuation drill each month. C. Home manager will document all staff training and drills on a monthly basis. D. Clinical supervisor will document that staff trainings are complete and observe and document evacuation drills. DHSR-Mental Health MAY 0 1 2018 Lic. & Cert. Section	6/1/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Program Manager 4/27/18

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 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, considering risk assessment and alternate placement and communication plan in case of an emergency evacuation of the clients in the facility. The findings include: The facility did not include a specific detailed alternate placement and communication plan within their emergency preparedness plan. Review on 4/3/18 of the facility policy on Emergency Plans and Sheltering out of home revealed relocation may be necessary for the safety of the individuals. And if the communication systems are working then staff in charge will contact management and discuss relocating the individuals. If communication system failure prevents this, the staff in charge should prepare to evacuate to a safe area. However, there was no information to indicate how communication would be relayed to other staff, guardians and/or authorities. The plan did not include specifics about relocation site(s) of the clients nor the communication between staff, guardians or any other the entity. During an interview on 4/3/18, a staff confirmed they were unsure as to where they would relocate	E 020	See page 1	

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E 020	Continued From page 2 if they had to relocate. The staff further confirmed they had not discussed neither had been presented with nor tested on any emergency preparedness information. During an interview on 4/3/18, the home manager confirmed they were unsure as to where they would relocate if they had to relocate. The facility is still in the process of identifying alternate shelter(s). Further interview confirmed they had not presented, discussed nor tested the staff on any emergency preparedness information nor shared any of the information with the guardians. During an interview on 4/3/18, management acknowledged they are still working on their plans and would have to look into means identifying alternate relocation shelter(s) and alternate means of communication.	E 020	See page 1	
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital	E 037	E 037 The noted deficiencies will be corrected by the following actions: A. New and existing staff will be trained on a monthly basis on the Emergency Preparedness Plan. B. Home manager will document each training and drills. C. Clinical supervisor will observe the training and document observations and confirm that training is completed.	6/1/2018

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E 037	Continued From page 3 or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency	E 037	See page 3	

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E 037	Continued From page 4 preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting	E 037	See page 3	

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E 037	Continued From page 5 equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to assure direct care staff were adequately trained on the facility's emergency preparedness policies and procedures. The finding is:	E 037	See page 3	

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E 037	Continued From page 6 Staff were not trained on the facility's emergency preparedness plans. During an interview on 4/3/18, staff revealed they had not received any training on the facility's emergency preparedness plans. The staff further stated they had recently received information about the emergency preparedness plans and had not read over the information in detail. During an interview on 4/3/18, management acknowledged they are still working on their emergency preparedness plans. Review on 4/3/18 of facility's emergency preparedness plans revealed no staff had received training on the facility's emergency preparedness plans. There was no documentation available for review to indicate the facility had conducted any emergency preparedness training.	E 037	See page 3	
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 co-guardians signed all documents jointly. This affected 1 of 3 audit client (#3). The finding is: Client #3's consents were signed by only one of two guardians.	W 125	W125 The noted deficiencies will be corrected by the following actions: A. Clinical supervisor will audit consumers' charts on a monthly basis to ensure that all consents requiring guardians' signatures are signed. B. Consents will be forwarded simultaneously by the clinical supervisor to guardians and co-guardians by the agreed upon method of transmission (i.e. mail, email, in person, etc.) to ensure all guardian signatures are obtained. C. The clinical supervisor will document the date along with the names of the guardians for any consents that were forwarded by mail or email and note any necessary follow-up completed to obtain all signed consents.	6/1/2018

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W 125	Continued From page 7 Review on 4/3/18 of client #3's guardianship papers revealed co-guardians. Review on 4/3/18 of client #3's behavior support plan (BSP) consent dated 2/22/18 revealed only one guardian's signature. During an interview on 4/3/18, the home manager confirmed client #3 currently has co-guardians.	W 125	See page 7	
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the privacy for 1 of 3 audit clients (#2) during toileting. The finding is: Client #2 was not provided privacy while using the toilet. During observations in the home on 4/2/18, client #4 went into the bathroom located near her bedroom and the kitchen. Staff was in the bathroom while client #2 was preparing for her shower. Client #2 had removed all of her clothing and was totally naked seated on the toilet. The staff exited the bathroom, leaving the bathroom door wide opened exposing client #2 seated on the toilet. The staff went over into the kitchen and carried on a conversation with the staff working in the kitchen. The door remained wide opened while client #2 was still seated on the toilet. The	W 130	W130 The noted deficiencies will be corrected by the following actions: A. Staff will be trained on the Protection of Clients' Rights to include privacy during treatment and care of personal needs. B. The group home manager will conduct an in-service and observe staff on a monthly basis to document staff training. C. Clinical supervisor will audit training documentation on a monthly basis to ensure that staff are trained on the Protection of Clients' Rights.	6/1/2018

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W 130	Continued From page 8 staff returned to the bathroom, leaving the bathroom door wide opened, put something down near the shower then came back and closed the bathroom door. Client #2 was not prompted to close the door nor was the door closed for her. During an interview on 4/2/18, staff stated they should have closed the door and they do not normally leave the doors open when the clients are in the bathroom. During an interview on 4/2/18, the qualified intellectual disabilities professional (QIDP) stated staff should not have left the door open while client #2 used the bathroom.	W 130	See page 8	
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on reviews and interviews the facility failed to assure outside services had access to relevant parts of each person's individual program plan. This affected 2 of 3 audit clients (#2 and #6). The findings are: Clients #2 and #6 did not have current behavior support plans (BSP) available at the day program. a. Review on 4/2/18 at the day program of client #2's record revealed a BSP dated 3/14/17. The	W 248	W 248 The noted deficiency will be corrected by the following actions: A. Staff will provide current Behavior Support Plans to staff, guardians, and agencies involved in providing services to clients within 10 business days of completing the BSP. B. Staff will be trained on the timeframe in which documentation should be made available to neccessary parties involved. C. Clinical Supervisor will document distribution of the documentation on a yearly basis and/or as the services plans are updated. D. Clinical Supervisor will audit each chart on a monthly basis to ensure that the necessary documentation is provided to service providers as required.	6/1/2018

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W 248	Continued From page 9 day program was not provided with a current 2018 BSP. Review on 4/3/18 of client #2's record in the home revealed a BSP dated 3/22/18. b. Review on 4/2/18 at the day program of client #5's record revealed a BSP dated 3/13/17. The day program was not provided with a current 2018 BSP. Review on 4/3/18 of client #6's record in the home revealed a BSP dated 3/1/18. During an interview on 4/3/18, the qualified intellectual disabilities professional (QIDP) revealed they had just submitted (4/3/18) the BSP's for client #2 and #6 to the day program.	W 248	See page 9	
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, interviews and record review, the facility failed to assure each client received a continuous active treatment plan consisting of needed interventions and services as identified in their individual program plan (IPP) in the area of meal preparation participation. This affected 2 of 3 audit clients (#2 and #6). The findings are:	W 249	W 249 The noted deficiency will be corrected by the following actions: A. Staff will be trained on the Program Implementation Protocols to include meal preparation. B. The group home manager will conduct an in-service and observe staff on a monthly basis to document staff training. C. Clinical supervisor will audit training documentation on a monthly basis to ensure that staff are trained on the Program Implementation Protocols.	6/1/2018

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W 249	Continued From page 10 1. Clients #2 and #6 were not consistently encouraged to participate in the dinner meal preparation. During observations of the dinner meal preparations on 4/2/17, the meal were prepared by staff. During the dinner meal preparation clients #2 and #6 were not prompted/encouraged to participate in preparing any of the food items. The staff preparing the foods only encouraged client #2 to obtain and discard items (used paper towels and used gloves) which was used by the staff. Clients #2 and #6 did not participate in the actual meal preparation. The dinner menu consisted of: Brussel sprouts, pork loin, brown rice and fruit cocktail. a. Review on 4/3/18 of client #2's IPP dated 3/22/18 revealed, "INTERESTS/NON-NEGOTIABLES Enjoys cooking." Review on 4/3/18 of client #2's community/home life assessment dated 3/14/18 revealed physical assistance is required when: "Makes food with no cooking. 3. Makes food with cooking but with no mixing. 4. Makes food with cooking and mixing....Uses Kitchen Appliances/Utensils....4. Stove/oven." b. Review on 4/3/18 of client #6's IPP dated 3/1/18 revealed, "INTERESTS/NON-NEGOTIABLES Enjoys cooking." Review on 4/3/18 of client #6's community/home life assessment dated 3/14/18 revealed physical assistance is required when: "Makes food with no cooking. 3. Makes food with cooking but with no	W 249	See page 10	

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W 249	Continued From page 11 mixing. 4. Makes food with cooking and mixing....Uses Kitchen Appliances/Utensils....4. Stove/oven." During an interview on 4/4/18, the qualified intellectual disabilities professional (QIDP) confirmed staff are to encourage the clients' to participate with all meal preparations including the use of the stove as the clients' abilities allow them to. 2. Client #2 was not afforded the opportunity to consistently cut her meat. During observations of the dinner meal in the home on 4/2/17, a staff obtained then meat for client #2, cut it into bite sized pieces while client #2 looked on. the staff used a rocker knife to perform this task. Client #2 was not prompted nor offered to independently cut her meat. Review on 4/3/18 of client #2's IPP dated 3/22/18 revealed a strength, "Participates in family style dining." Review on 4/3/18 of client #2's community/home life assessment dated 3/14/18 revealed independence in the area of using a knife and eats family style.	W 249	See page 10	
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by:	W 322	W 322 The noted deficiency will be corrected as follows: A. Staff will be trained on the protocol for scheduling preventative and general medical care for the residents. B. Staff will prepare documentation prior to each appointment to ensure all information is obtained during the visit.	6/1/2018

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W 322	Continued From page 12 Based on record reviews and interviews, the facility failed to assure 3 of 3 female audit clients (#2, #3 and #6) obtained a pap smears. The findings are: Clients #2, #3 and #6 did not receive their annual pap smears. Review on 4/3/18 of client #2's record did not reveal information for a current gynecology (GYN) evaluation. Review of client #2's physical examination dated 6/8/17 revealed, "Pelvic Exam...01/15 NL (-) - 2020." The home manager revealed the physician stated client #2 was not to receive a PAP until the year 2020. However, the was no information from the physician as to the reason for the delay nor was there any current team meeting information to indicate the teams discussion about the delay. Review on 4/3/18 of client #3's record did not reveal information for a current gynecology (GYN) evaluation. Review on 4/3/18 of client #3's GYN report dated 10/26/17 did not reveal any information to indicate a GYN assessment was completed. The home manager revealed client #3 was not assessed during the 10/2617 visit, the physician only obtained information about the new birth control medication she was receiving. Review on 4/3/18 of client #6's record did not reveal information for a current gynecology (GYN) evaluation. Client #6's last PAP/pelvic examination was dated 1/31/17. Review on 4/3/18 of client #6's physical examination dated 9/14/17 revealed, "Genito - Urinary N/A....Sees OB/GYN." During an interview on 4/3/18, the home manager	W 322	Continued from page 12 C. Home manager will review documentation prior and after each visit to ensure medical appointments are complete to include any necessary follow-up items and physician rationale for treatment decisions. D. The interdisciplinary team will meet each month and document review of physician's findings for all consumer medical appointments. E. The nurse will audit each chart on a weekly basis to ensure all appointments are scheduled and/or attended and that the needed information was captured. F. The clinical supervisor will audit each chart on a monthly basis to make sure documentation is present noting the interdisciplinary teams' review of physicians' findings, treatment recommendations, and rationale.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G115	A. BUILDING _____ B. WING _____	04/03/2018

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W 322	Continued From page 13 revealed the the qualified intellectual disabilities professional (QIDP) was to write a note about the pap smears and no information could be located to indicate any meeting were held to discuss the clients and their pap smears. She further stated she thought it was to be completed yearly or as ordered by the physician.	W 322	See page 12 and 13	
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to assure each client received adequate annual physical examination which included a visual evaluation. This affected 1 of 3 audit clients (#3). The finding is: Client #3 did not receive an adequate annual physical to include a visual evaluation. Review on 4/3/18 of client #3's physical evaluation dated 3/14/18 revealed her vision was not assessed. Further review of the physical evaluation form revealed, "REFERRAL/FOLLOW UP: ...Vision." The current information available for review did not reveal a complete 2018 physical evaluation, which included a visual assessment was completed. During an interview on 4/3/18, the home manager confirmed client #3's vision was not assessed during her annual physical and the physician referred her out to have her eyes assessed.	W 323	W 323 The noted deficiency will be corrected as follows: A. Staff will be trained on the protocol for scheduling preventative and general medical care for the residents. B. Staff will prepare documentation prior to each appointment to ensure all information is obtained during the visit. C. Home manager will review documentation prior and after each visit to ensure medical appointments are complete to include any necessary follow-up items. D. The nurse will audit each chart on a weekly basis to ensure all appointments are scheduled and/or attended and that the needed information was captured to include any follow-up appointments. E. The clinical supervisor will audit each chart on a monthly basis to make sure documentation is present noting the interdisciplinary teams' review of physicians' findings, treatment recommendations, and rationale.	6/1/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 323	Continued From page 14 Further interview confirmed client #3 was in need of having her eyes assessed.	W 323	See page 14	