	HUMAN SERVICES				M APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
	34G305	B. WING		0(6/06/2018
NAME OF PROVIDER OR SUPPLIER BROOKWOOD			STREET ADDRESS, CITY, STATE, ZIP CODI 313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
ASCs, PACE organizati and dialysis facilities] m (i) Initial training in emer policies and procedures staff, individuals providir arrangement, and volum expected role. (ii) Provide emergency p least annually. (iii) Maintain documenta (iv) Demonstrate staff kr procedures. *[For Hospitals at §482. at §491.12:] (1) Training or RHC/FQHC] must do (i) Initial training in emer policies and procedures staff, individuals providir arrangement, and volum expected roles. (ii) Provide emergency p least annually. (iii) Maintain documenta (iv) Demonstrate staff kr procedures. *[For Hospices at §418. hospice must do all of th (i) Initial training in emer policies and procedures hospice employees, and	hust do all of the following: rgency preparedness is to all new and existing ing services under inteers, consistent with their preparedness training at ation of the training. nowledge of emergency .15(d) and RHCs/FQHCs g program. The [Hospital o all of the following: rgency preparedness is to all new and existing ing on-site services under inteers, consistent with their preparedness training at ation of the training. nowledge of emergency .113(d):] (1) Training. The he following: rgency preparedness is to all new and existing d individuals providing ment, consistent with their	E 03			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

TITLE

(X6) DATE

PRINTED: 06/11/2018

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	06/11/2018 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	-	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		34G305	B. WING		_	06/	06/2018
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
BROOKW	OOD			13 EAST BROOKWOOD . LIBERTY, NC 27298	AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	least annually. (iv) Periodically review emergency preparedr employees (including special emphasis place procedures necessary others. *[For PRTFs at §441. program. The PRTF r (i) Initial training in em- policies and procedur staff, individuals provi arrangement, and vol expected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document preparedness training *[For PACE at §460.8 organization must do (i) Initial training in em- policies and procedur staff, individuals provi arrangement, contract volunteers, consistent (ii) Provide emergenc least annually. (iii) Demonstrate staff procedures, including	cy preparedness training at w and rehearse its ness plan with hospice nonemployee staff), with ced on carrying out the y to protect patients and 184(d):] (1) Training must do all of the following: nergency preparedness res to all new and existing iding services under unteers, consistent with their g, provide emergency g at least annually. F knowledge of emergency g. 44(d):] (1) The PACE all of the following: nergency preparedness res to all new and existing iding on-site services under tors, participants, and t with their expected roles. by preparedness training at f knowledge of emergency informing participants of go, and whom to contact in y.	E 037				

DEPARTMENT OF HEAL CENTERS FOR MEDICA							FORM	D: 06/11/2018 APPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		34G305	B. WING			_	06/	06/2018	
NAME OF PROVIDER OR SUPPLI	ER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
BROOKWOOD					13 EAST BROOKWOOD A IBERTY, NC 27298	VENUE			
PREFIX (EACH DEF	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
CORF must do (i) Provide initia preparedness p and existing sta under arrangen with their expect (ii) Provide eme least annually. (iii) Maintain do (iv) Demonstrat procedures. All and assigned s the CORF's em their first workd include instruct alarm systems equipment. *[For CAHs at § The CAH must (i) Initial training policies and pro reporting and e and where neod personnel, and cooperation wit authorities, to a individuals prov and volunteers, roles. (ii) Provide eme least annually. (iii) Maintain do (iv) Demonstrat procedures.	§485 all of I train olicie: ff, ind nent, a ted ro- ergeno cumel e staf new p pecific ergen av. Th on in and si g485.6 do all g in er bocedun xtingu guest h firefi II new iding consi ergeno cumel e staf g in er bocedun xtingu essary guest	.68(d):](1) Training. The the following: ing in emergency s and procedures to all new lividuals providing services and volunteers, consistent	E	037					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/11/2018 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		34G305	B. WING			-	06/	06/2018
NAME OF PROVIDER OR SUPPLIER			-	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
BROOKW	OOD				13 EAST BROOKWOOD A IBERTY, NC 27298	VENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
E 037	preparedness policies and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff kno procedures. Thereafte emergency preparedr annually. This STANDARD is r Based on interview a failed to ensure direct trained on the facility's finding is: Staff had not received Review on 6/5/18 of the revealed no document direct care staff in reg Staff interview (1) on been trained regardin drills; however, the st facility's EP program. Staff interview (1) on been trained regardin and trained on the face Interview on 6/5/18 w disabilities profession care staff have not re- concerning the EP be	initial training in emergency is and procedures to all new ividuals providing services and volunteers, consistent iles, and maintain training. The CMHC must owledge of emergency er, the CMHC must provide ness training at least not met as evidenced by: and record review, the facility it care staff were sufficiently is emergency plan (EP). The d training on the EP. the facility's documentation need specific training for gards to the EP. 6/5/18 revealed they have ig fire drills and disaster aff were not trained on the 6/6/18 revealed they have ig fire drills, disaster drills cility's EP. ith the qualified intellectual ial (QIDP) confirmed direct ceived any training ecause it was new. LIENTS RIGHTS		037				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FORM	D: 06/11/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	34G305	B. WING			06/	06/2018
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKWOOD				313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 125 Continued From page	: 4	w	125			
 Therefore, the facility individual clients to exof the facility, and as of including the right to fit to due process. This STANDARD is n Based on record revisifailed to ensure client This affected 1 of 3 at Client #2 has no docu guardian. Review on 6/6/18 of c no documentation to of guardian. Interview on 6/6/18 wild disabilities professions #2's record has no do has a legal guardian; confirmed she would withe documentation. W 164 PROFESSIONAL PROFES	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 ensure client #2 had a legal guardian. This affected 1 of 3 audit clients. The finding is: Client #2 has no documentation of a legal guardian. Review on 6/6/18 of client #2's record revealed no documentation to confirm she has a legal guardian. Interview on 6/6/18 with qualified intellectual disabilities professional (QIDP) confirmed client #2's record has no documentation to confirm she has a legal guardian; however, the QIDP confirmed she would work expediently to obtain the documentation.		164			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/11/2018 APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		34G305	B. WING			_	06/	06/2018	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
BROOKW	OOD				313 EAST BROOKWOOD A LIBERTY, NC 27298	AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
W 164	defined by the individ requires the knowledg someone specially tra This affected 1 of 3 ar is: The facility has not has since her admission. Review on 6/6/18 of or review dated 4/24/18 notes indicating she is health provider" and h "Adjustment Disorder F43.23." Review on 6/6/18 of or nursing assessments revealed the following psychEvaluation. pla health provider." Review on 6/6/18 of or revealed a behavior s 8/31/17 of which inco techniques and the us medications - Klonop review of client #4's or individual program pla revealed no recent ps Interview on 6/6/18 w client #4 has not seer admission. Interview on 6/6/18 w	ual program plan (IPP) ge, skills and expertise of ained in a given discipline. udit clients (#4). The finding ad a psychiatrist for client #4 client #4's quarterly drug revealed the pharmacist's is in need of a "behavior her diagnosis includes - Mixed Emotional Features client #4's recent quarterly dated 5/3/18 and 2/27/18 g: "Need for an fir seeking behavior client #4's current records support plan (BSP) dated rporates restrictive se of psychotherapeutic in and Abilify. Additional current records including her	W	164					

Facility ID: 924983

If continuation sheet Page 6 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY				
and plan of	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED				
		34G305	B. WING		06/06/2018				
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE					
BROOKWOOD				313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETI				
W 164	psychotherapeutic m However, the QIDP c has not seen a psych on 7/28/15 and was i	e 6 edications listed on her BSP. confirmed on 6/6/18 client #4 liatrist since her admission n need of a psychiatrist to n BSP psychotherapeutic	, W 16	:4					
W 285	MGMT OF INAPPRC BEHAVIOR CFR(s): 483.450(b)(2		W 28	15					
	behavior must be em safeguards and supe	rvision to ensure that the vil and human rights of							
	Based on observation interview, the facility to manage inappropri employed with sufficient supervision to ensure	failed to ensure interventions iate client (#2) behavior be ent safeguards and e that the safety, welfare and s of clients are adequately							
	Client #2 directed oth home to go take their	er clients residing in the medications.							
	morning medication a instructing clients sea to go take their medic technician requested am on 6/6/18, staff to medications. Then cli	18 in the home during administration revealed staff ated in the home's living area cations as the medication each. At approximately 8:05 Id client #5 to go take her ent #2 said, "Client #5 go lications" and "Client #5 go medications."							

Event ID: I5XR11

Facility ID: 924983

If continuation sheet Page 7 of 8

	-	ID HUMAN SERVICES				FORM): 06/11/2018 1 APPROVED
STATEMENT C	S FOR MEDICARE & N OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION		(X3) DATE	
		34G305	B. WING		_	06/0	06/2018
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
BROOKW			31	3 EAST BROOKWOOD A	VENUE		
BROORW			LI	BERTY, NC 27298			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 285	Continued From page	27	W 285				
	during morning medic approximately 8:15am instructing another pe medications after staff client #1 to go take he approximately 8:25am go take her medicatio heard also instructing medications. At no tim redirecting client #2's take their medications Interview on 6/6/18 wi just loves to talk" and clients what to do; how any mind." In addition is not addressed in cli plan (BSP). Review on 6/6/18 of c plan (IPP) dated 3/30/ 4/17/18 for the client t behaviors including "F destruction/misuse" Aggression/Inappropr yelling, threats, name "Noncompliance/Resi Behavior (SIB)" Interview on 6/6/18 wi disabilities professiona time should client #2 i their medications or in anything. Further, the	eer (client #1) to go take her if had already instructing er medications. Then, at n, staff instructed client #6 to ons and client #2 again was o client #6 to go take her ne was staff observed behavior of telling clients to s. with staff revealed "client #2 "she tries to tell" other wever, clients "don't pay her n, staff revealed this behavior ient #2's behavior support client #2's individual program /18 revealed a BSP dated to decrease inappropriate Property ' and "Verbal riate Languagecursing, e calling" and istance" and "Self Injurious ith the qualified intellectual hal (QIDP) confirmed at no instruct other clients to take nstruct clients to do e QIDP confirmed client #2's itressing her behaviors of					

Facility ID: 924983

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