DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G179	A. BUILDING _____ B. WING _____	05/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH DRIVE GROUP HOME	1216 NORTH DRIVE GOLDSBORO, NC 27534

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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 interview and record review, the facility failed to develop specific facility-based strategies as part of their emergency plan. The finding is: Facility management staff failed to develop specific strategies to address the possible hazards to the clients who reside in the facility	E 006	**Plan Based on All Hazards Risk Assessment** **CFR(s): 483.475(a)(1) – (2)** The facility will progressively conduct and document a community and facility-based (all-hazards approach) risk assessment. The facility will utilize information collected from the community and facility-based (all-hazards) risk assessment to update current emergency plan. Staff will be progressively trained on hazards, risks, and strategies for addressing emergency events identified by the risk assessment. *To promote efficiency, Nova will create a timeline for implementation at other facilities to meet globalization requirements.* ***Responsible Persons:*** Nova's Leadership Council, Health & Safety Chairperson and Committee, QP, RSS ***Frequency/Monitoring:*** Reviewed at least annually and updated as deemed necessary. DHSR - Mental Health JUN 07 2018 Lic. & Cert. Section	7-21-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Candace Hall — TITLE: Program Director — (X6) DATE: 5-31-18

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 given an emergency situation. Review on 5/21/18 of the facility's emergency management plan revealed there was no thorough assessment of the hazards and risks given the geographic area of the facility. There was general information in this plan about power outages and bomb threats, however there was not specific information for the direct care staff at the facility about the possible hazards that may occur given the location of the facility. Interviews on 5/21/18 with direct care staff (2) revealed they were not aware of the possible hazards or risks the facility may encounter in the event of an emergency and management of the facility had not discussed this with them. Interview on 5/21/18 with facility management staff revealed there had not been an all hazards risks assessment completed for this facility.	E 006		7-21-18

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;	E 020	**Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3)** The facility will progressively develop specific policies and update procedures to address emergency preparedness plans based upon the community and facility-based (all-hazards approach) **risk assessment**. The facility will progressively develop specific policies and update procedures to address the development and maintenance of a **primary and alternate communication plan**. Staff will be trained on policies and procedures relative to emergency preparedness plans. **Responsible Persons:** Nova's Leadership Council, Health & Safety Chairperson and Committee, QP, RSS **Frequency**: Initially, Annually, and as deemed necessary.	7-21-18

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E 020	Continued From page 2 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 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:	E 020		

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E 020	Continued From page 3 The facility did not include a specific detailed alternate relocation and communication plan within their emergency preparedness plan. Review on 5/21/18 of the facility's Emergency Plans revealed relocation may be necessary for the safety of the individuals. Information in the plan indicated if the communication systems were working, the staff in charge would contact management and discuss relocating the individuals. If communication systems failure prevents this, the staff 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 5/21/18, the residential manager confirmed there was no specific information about relocating the clients in the event of an emergency. Further interview revealed management of the facility did not have any information on the emergency preparedness of the facility to discuss with any of the direct care staff and the guardians. During an interview on 5/21/18, program director confirmed management staff are still working on their emergency management plans and would have to look into means identifying alternate relocation shelter(s) and alternate means of communication. The plans did not include all of the components outlined in the emergency preparedness plan.	E 020		

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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 5/21/18 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 other in the event of an emergency. Interview on 5/21/18 with the Qualified Intellectual	E 032	**Primary/Alternate Means for Communication** **CFR(s): 483.475(c)(3)** The facility will update the current emergency preparedness communication plan with primary and alternate means of communication. Staff will be trained on the updated emergency communication plan with primary and alternate means of communication. **Responsible Persons:** Nova's Leadership Council, Health & Safety Chairperson and Committee, QP, RSS **Frequency/Monitoring:** Reviewed annually and updated as deemed necessary.	7-21-18

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E 032	Continued From page 5 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 Wayne county.	E 032		
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must	E 036	**EP Training Program** **CFR(s): 483.475(d)(1)** The facility will develop an emergency training program for new and existing staff consistent with their expected role. All new and existing staff will be trained on an initial and annual basis according to the objectives identified in the training program. The facility will maintain documentation relative to training provided to staff. **Responsible Persons:** Nova's Leadership Council, Health & Safety Chairperson and Committee, QP, RSS **Frequency/Monitoring:** Initially, annually, and as deemed necessary.	7-21-18

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E 036	Continued From page 6 develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to develop an emergency management preparedness (EMP) training and testing program. The finding is: The facility failed to develop an EMP training and testing program. Review on 5/21/18 of the facility's EMP manual, it did not include any information on training or testing of the facility's emergency preparedness plans. Interview on 5/21/18, direct care staff confirmed they had not been trained on the facility's EMP. Additional interview confirmed direct care staff could only provide the training for fire and tornado drills. Interview on 5/21/18, the qualified intellectual disabilities professional (QIDP) confirmed there was no documentation for direct care staff training or testing regarding the EMP.	E 036		