PRINTED: 04/19/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	C EOD MEDICADE O						MAPPROVED	
		MEDICAID SERVICES		-		OMB NO	<u>0. 0938-0391</u>	
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION CONTRICTION NUMBER: A. BUILDING			(X3) DATE	SURVEY PLETED			
		34G169	B, WING_			04	/17/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			717/2014	
FOIFNBIN	AV Challa Lieus		202 FRIENDWAY ROAD			• :		
PRIENDW	AY GROUP HOME				REENSBORO, NC 27409	:		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	!	PROVIDER'S PLAN OF CORRECTION	1.	` (x5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION		
E 000	Initial Comments		Ε¢	000		7:		
	CONDITIONS OF PA INTERMEDIATE CAR PERSONS WITH ME	RE FACILITIES FOR NTAL RETARDATION			DHSR - Mental F	lealth		
	FOUND AT 42 CFR 4 42 CFR 483,480 (GEI REQUIREMENTS)."	83,400 THRU 483,460 AND NERAL/HEALTH			JUN 11 2018			
E 004		view and Update Annually	E	004	Lic. & Cert. Sec	tion	•	
	Federal, State and loc preparedness require develop establish and	ments. The [facility] must maintain a comprehensive less program that meets the			E004 The facility will develop a	; ;	6/16/18	
	* [For hospitals at §48	2.15 and CAHs at		Ī	comprehensive emergency			
		spital or CAH) must comply		1	preparedness plan that meets			
		less requirements. The		,	the requirements including a risk			
		t develop and maintain a			assessment. The plan will be			
	comprehensive emerg	jency preparedness le requirements of this			assessment. The plan will be		Į	
	section, utilizing an all				reviewed at least annually and			
	include, but not be lime elements:]			***************************************	updated. Staff will be inserviced of emergency plan at least annually. QP/Program Manager will monitor			
		The (facility) must develop gency preparedness plan	;		monthly and update plan at least			
	that must be freviewed	d], and updated at least	:	ì	annually.	:	j	
:		willams		;	willingity.			

LABORATORY DIRECTOR'S OR PROVIDER/BUPPLIER REPRESENTATIVES SIGNATURE

* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that

TITLE

(XB) DATE

Any deliciency statement ending with an esterisk (*) denotes a deliciency 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.

FORM CMS-2587(02-99) Previous Versions Obsolete

annually.

Event ID: IXIX11

Facility ID: 921809

If continuation sheet Page 1 of 7

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

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AND PLAN OF CORRECTION	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	34G160	B. WING			04/	17/2018
NAME OF PROVIDER OR SUPPLIER FRIENDWAY GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 202 FRIENDWAY ROAD GREENSBORO, NC 27409		2 FRIENDWAY ROAD		
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(XS) COMPLETION DATE	
falled to ensure an accept was performed to address (e.g. natural, man-made, in the facility's emergencies: The EP risk assessment Review on 4/16/18 of fact the following: There was completed to address an natural, man-made, facility. Interviews on 4/16/18 with intellectual disabilities pro	met as evidenced by: record review, the facility blable risk assessment as and identify hazards facility, geographic, etc.) y plan (EP). The finding was not performed, fillity documents revealed no risk assessment d identify hazards (e.g., ty, geographic, etc.) for the qualified blessional (QIDP) for of the need to perform elephone with the facility e agency was not aware for the EP or how it fullation full facility is must develop for preparedness plan full dupdated at least full the following: population, including, for at-risk; the type of		004			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		34G169	B. WING			04/	17/2018
NAME OF PROVIDER OR SUPPLIER FRIENDWAY GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 202 FRIENDWAY ROAD GREENSBORD, NC 27409			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
E 007	including delegations plans.** *Note: ["Persons at rithospice, PACE, HHA FQHC, or ESRD facil This STANDARD is a Based on interview falled to ensure an awas performed to adopopulation served in (EP). The finding is: The EP risk assessment as a falled to ensure an acceptance of the client population of the following: A training and the evacuation prisk assessment available client population at the interviews (2) on 4/16 intellectual disabilities the facility administra	ontinuity of operations, of authority and succession sk" does not apply to: ASC, CORF, CMCH, RHC, lities.] not met as evidenced by: and record review, the facility coeptable risk assessment dress the needs of the the facility's emergency plan lent was not specific to the application. I facility documents revealed ing for fire and tornado drills rocedures. There was no lable specific to the at-risk	E	007	The facility will develop a comprehensive emergency preparedness plan that meets the requirements including a risk assessment. The plan will address following: population served, type service provided, and ability to preservice in the event of an emergent The plan will be reviewed at least annually and updated. Staff will inserviced on the emergency plantest annually. QP/Program Manwill monitor monthly and update at least annually.	ss the cost of the	bliblis
E 013	the specific needs of	the facility population. Policies and Procedures	E	013			
	develop and impleme policies and procedur plan set forth in parag assessment at parag and the communicati	edures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cles and procedures must be					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• - • · · · ·	X2) MULTIPLE CONSTRUCTION A. BUILDING			URVEY ETED
		. 34G169	B. WING			04/1	7/2018
NAME OF PROVIDER OR SUPPLIER FRIENDWAY GROUP HOME				21	TREET ADDRESS, CITY, STATE, ZIP CODE 02 FRIENDWAY ROAD DREENSBORO, NC 27409		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC.IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 013	*[For PACE at §460.6 procedures, The PAC develop and impleme policles and procedure plan set forth in paragand the communication this section. The polic address managemen emergencies, includir equipment, power, or emergencies; and na threaten the health or staff, or the public. The must be reviewed and "[For ESRD Facilities procedures, based or forth in paragraph (a) assessment at paragand the communication this section. The polic reviewed and update emergencies include equipment or power in emergencies, water so natural disasters likely geographic area. This STANDARD is Based on interview, specific policles and	d at least annually. ents for PACE and ESRD 34(b):] Policies and EE organization must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cles and procedures must et of medical and nonmedical eng, but not limited to: Fire; rewater fallure; care-related tural disasters likely to resafety of the participants, ene policies and procedures d updated at least annually. Eat §494.62(b):) Policies and ey preparedness policies and en the emergency plan set ey of this section, on plan at paragraph (c) of cles and procedures must be d at least annually. These en but are not limited to, fire,	H	013	E0013 The facility will develop and male mergency preparedness plant reviewed and updated annually. The facility will ensure that the plassed on a community-based rist assessment and includes missing clients/communication and idenstrategies for addressing identificities/client's needs. Facility will inservice staff on identified emergence manager will monitor plan montensure that the needs/strategies accurately identified and address	hat is plan is tifled ed rgency hly to are	6/16/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		Improvemental and a Children and the		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
	_	34G169	B, WING_			041	17/2018	
FRIENDWAY GROUP HOME				STREET ADDRESS. CITY, STATE, ZIP CODE 202 FRIENDWAY ROAD GREENSBORO, NC 27409				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E ((X8) COMPLETION DATE	
	case of an emergence the facility. The finding the facility. The finding price of the facility. The finding an interview of revealed they did not procedures specifical preparedness plan. Primary/Alternate Met CFR(s): 483.475(c)(3) [(c) The [facility] must emergency prepared that complies with Fe and must be reviewed annually.] The commall of the following: (3) Primary and altern communicating with I (I) [Facility] staff. (II) Federal, State, trill emergency managent of ICF/IID's staff. Feder local emergency marth is STANDARD is Based on document facility failed to devel communicating with I local governments dufinding is:	r communication plan in y evacuation of the clients in ng is: n 4/16/18, with management have policies and ly for the emergency ans for Communication it develop and maintain an mess communication plan ideral, State and local laws d and updated at least unication plan must include in the following: pal, regional, and local ment agencies. 3.475(c):] (3) Primary and communicating with the al. State, tribal, regional, and negement agencies. not met as evidenced by: atlon and interviews, the op an alternate means for facility staff, regional and uring an emergency. The		032	The facility will develop and malemergency preparedness plant reviewed and updated annually plan will address primary and almeans of communicating with semergency management agency oversight agencies. The facility identify primary and alternate recommunication and inservice stomorphisms of the communication and inservice stomorphisms. QP/Program Manager will monimonthly to ensure that the needs/strategles are accurately identified and addressed.	hat is . The ternate staff, ies, and will neans of saff. ltor plan	ه الدالة	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER:	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION (X3)	ORM 3 NO DATE S	: 04/19/2016 APPROVED : 0938-0391 SURVEY	
and Plan of Correction		IDENTIFICATION NUMBER:	A. BUILDING			COMPL	.ETED	
		34G160	B. WING			04/1	17/2018	
	ROVIDER OR SUPPLIER			20	reet address, city, state, zip code 12 Friendway Road REENSBORO, NC 27409		•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
E 032	Continued From page	e 5	E	032				
E 036	preparedness (EP) dinformation regarding communication. During an interview of revealed if the land lift were down there was communicate during EP Training and Test CFR(s): 483.475(d) (d) Training and testif develop and maintain preparedness training based on the emerge paragraph (a) of this peragraph (a) of this peragraph (a)(1) of the procedures at paragraph the communication pection. The training be reviewed and upder "[For ICF/IIDs at §48 testing. The ICF/IID is an emergency prepared program that is base forth in paragraph (a) assessment at paragraph (c) of this testing program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIDs at garding program mus least annually. The ICF IIIDs at garding program mus least annually. The ICF IIDs at garding program mus least annually. The ICF IIDs at garding program mus least annually.	an 4/16/18, management ne phone and cell service not another way to an emergency. Ing Ing. The [facility] must n an emergency g and testing program that is ency plan set forth in section, risk assessment at his section, policies and each (b) of this section, and lan at paragraph (c) of this and testing program must lated at least annually. 3.475(d):) Training and must develop and maintain redness training and testing d on the emergency plan set of this section, risk iraph (a)(1) of this section, res at paragraph (b) of this	·	036	E036 The facility will develop and maintain emergency preparedness plan that is reviewed and updated annually. The facility will ensure that the plan is based on a community-based risk assessment and includes missing clients/communication and identified strategles for addressing identified risks/client's needs. Facility will inservice staff on identified emergen preparedness plan. QP/Program Manager will monitor plan monthly ensure that the needs/strategles are accurately identified and addressed.	is dd tto	6/16/18	

; DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NAME OF PROVIDER OR BUPPLIER FRIENDWAY GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFINITION OF THE PROVIDER OF THE CODED BY TULL ASSULATION OR THE PROVIDER OF THE PROPORTION OF THE PROPOR	STATEMENT OF DEFICIENCIES ' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
PRIENDWAY GROUP HOME CAN ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PRIEFIX TAG PROVIDENS PLAN OF CORRECTION (EACH OGRAGE TIVE ACTION SHOULD BE CARDS-AREFERENCED TO THE APPROPRIATE DEFICIENCY) E 036 Continued From page 6 (For ESRO Facilities at §494.62(d);) Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and pallent orientation program that is based on the emergency plan set forth in paragraph (a) of this section, pilots each procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section, and the communication plan at paragraph (c) of this section, and the termination program must be reviewed and updated at least annually. This STANDARD is not mel as evidenced by: Based on document review and interviews, the facility failed to develop an emergency preparedness (EP) training and testing program. The finding is: The facility failed to develop an EP training and testing program. Review on 4/16/18 of the facility's EP manual, it did not include any information on training or testing for the staff. During an Interview on 4/17/18, staff revealed they had not been tested on the EP and they could only provide the training for fire and tormado drills. During an Interview on 4/16/18, the qualified intellectual disabilities professional (QIDP) confirmed there was no documentation for staff.			34G169	B, WING_			04/17/2018		
E 036 Continued From page 6 "[For ESRD Facilities at §494.62(d):] Training, testing, and orientation program that is based on the emergency plan set (don't in section, policies and procedures at paragraph (b) of this section, policies and procedures at paragraph (b) of this section, policies and updated at least annually. This STANDARD is not met as evidenced by: Based on detelluling program. The facility failed to develop an emergency preparedness (EP) training and desting program. The facility failed to develop an EP training and testing program. Review on 4/16/18 of the facility's EP manual, it did not include any information on training or testing for the staff. During an interview on 4/17/18, staff revealed they had not been tested on the EP and they could only provide the training for fire and tornado drills. During an interview on 4/16/18, the qualified intellectual disabilities professional (IQIDP) confirmed there was no documentation for staff.					202 FRIE	NDWAY ROAD			
*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must 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, policles and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) 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 document review and interviews, the facility failed to develop an emergency preparedness (EP) training and testing program. The finding is: The facility failed to develop an EP training and testing program. Review on 4/16/18 of the facility's EP manual, it did not include any information on training or testing for the staff. During an interview on 4/17/18, staff revealed they had not been tested on the EP and they could only provide the training for fire and tornado drills. During an interview on 4/16/18, the qualified intellectual disabilities professional (QIDP) confirmed there was no documentation for staff	PREFIX	(EACH DEFICIENC	PREFI	\	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION		
· · · · · · · · · · · · · · · · · · ·	E 036	*[For ESRD Facilities lesting, and orientation develop and maintair preparedness training orientation program to emergency plan set of section, risk assessmenths section, policies (b) of this section, an paragraph (c) of this and orientation progrupdated at least annual This STANDARD is Based on document facility failed to developreparedness (EP) to the finding is: The facility failed to developreparedness (EP) to the staff. During an interview of they had not been to could only provide the drills. During an interview of intellectual disabilities confirmed there was	at §494.62(d):] Training, on. The dialysis facility must on an emergency g, testing and patient hat is based on the forth in paragraph (a) of this nent at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training, testing and must be reviewed and ually. not met as evidenced by: review and interviews, the lop an emergency raining and testing program. develop an EP training and fine facility's EP manual, it information on training or on 4/17/18, staff revealed sted on the EP and they be training for fire and tornado on 4/16/18, the qualified is professional (QIDP) no documentation for staff	E	036				