DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/24/2018 FORM APPROVED

STATEMENT OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			COMPLETED	
7,110,101	O I I I I I I I I I I I I I I I I I I I		A. BUILDING	G		
		34G319	D. WING		05/	23/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				135 DAUGHTRY FIELD ROAD		
DAUGHTF	RY FIELD ROAD GROUP	HOME		MOUNT OLIVE, NC 28365		
(X4) ID	CHAMADY CT	ATEMENT OF DEFICIENCIES	ID	BROWINEDIS DI ANI OF CORDECT	TON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	OPRIATE	DATE
				DEFICIENCY)		
E 006			E 00	06 Plan Based on All Hazards Risk A	ssessment	7-21-18
, i	DI DI AU II-		,	CFR(s): 483.475(a)(1) - (2)		
		zards Risk Assessment				
	CFR(s): 483.475(a)(1)-(2)		The facility will progressively cond		
	[/a] [The Medital accept develop		document a community and facility	-based	
		The [facility] must develop		(all-hazards approach) risk assessi	nent.	
		rgency preparedness plan				
		d, and updated at least		The facility will utilize information c	ollected	
	annually. The plan m	ust do the following.]		from the community and facility-base		
	(1) Be based on	and include a documented,		hazards) risk assessment to update	current	
	, ,	nmunity-based risk assessment,		emergency plan.		
	utilizing an all-hazard					
	dilizing an all-nazard	з арргоаст.		Staff will be progressively train		
	*IFor LTC facilities at	§483.73(a)(1):] (1) Be based		hazards, risks, and strategi		
		umented, facility-based and		addressing emergency events iden	iified by	
		k assessment, utilizing an all-		the risk assessment.		
		cluding missing residents.				
	nazarao approaon, m	oldaning miconing roomerine.		To promote efficiency, Nova will cre		
	*IFor ICF/IIDs at \$48	3.475(a)(1):] (1) Be based on		for implementation at other facili	ies to mee	t
		ented, facility-based and		globalization requirements.		
		k assessment, utilizing an all-				
		cluding missing clients.		Responsible Persons: Nova's	Londorobir	
	, ,			Council, Health & Safety Chair		
	(2) Include strate	egies for addressing emergency		Committee, QP, RSS	person and	*
	events identified by the					
	,			Frequency/Monitoring: Reviewe	d at leas	tl .
	* [For Hospices at §4	18.113(a)(2):] (2) Include		annually and updated as deemed n		
ļ	strategies for address	sing emergency events			•	-
	identified by the risk a	assessment, including the				
	management of the o	consequences of power		- 4 8 8 9 0	166-	
		sters, and other emergencies		DHSR - Mental He	aiui	
E	that would affect the	hospice's ability to provide				
	care.			JUN 07 2018		
		not met as evidenced by:		JOH 0 : 23 : 1		
		iew and interview, the facility			A (5)	
		emergency preparedness		Lic. & Cert. Sect	UII	
		nd based upon a community				
		k assessment, utilizing an all-				
	hazards approach. T	he finding is:				
	Triange in the second					
LADODATORY		ave an emergency plan		TITLE		((0) 5:==
LABOHATORY	\	SUPPLIER REPRESENTATIVE'S SIGNATURE		Discourse Ois a cha	<i>.</i> ، سر	(X6) DATE
("Moure			Program Directo	(5	-31-1

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM

APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-

0391

program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:4UWR11

Facility ID: 955398

If continuation sheet Page 1 of 13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPA	DEPARTMENT OF HEALTH AND HUMA FAISTELICTION	COMPLET		OI
			A. BUILDING _	CENTERS FOR ME DICARE & MEDICAI	D SERVICE	S OMB	N
		34G319	B. WING0g	38-0391	05/23/	2018	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DAUGHTE	RY FIELD ROAD GROU	P HOME	i	35 DAUGHTRY FIELD ROAD IOUNT OLIVE, NC 28365			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	E C	(X5) OMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
E 006			E 006	,		7-21-18	
1 000	Continued From pag	ne 1	L 000	,		, 21 10	l
	based upon risk	, .					l
	assessments.	:					
		of the facility's current EP plan d 5/15/99, updated 12/26/02)					
		d not provide specific					
İ	information in regard	ds to a facility-based and					
		sk assessment using an all- ncluding flood, fire, tornadoes,					l
		torms, bio terrorism, missing					
	clients or other eme						
	Intoniow on 5/23/18	with the Qualified Intellectual					
		onal (QIDP) revealed the					
		a risk assessment for their					
	EP plan; however, it of the date of the su	has not been completed as					l
E 013		Policies and Procedures	E 013	Development of EP Policies and		7-21-18	ļ
	CFR(s): 483.475(b)			Procedures			
	(h) Policies and prod	cedures. [Facilities] must		CFR(s): 483.475(b)			İ
		ent emergency preparedness		The facility will progressively develop	specific		
	1 '	ures, based on the emergency		policies and update procedures to			
		agraph (a) of this section, risk graph (a)(1) of this section,		emergency preparedness plans based ucommunity and facility-based (all-	•		
		tion plan at paragraph (c) of		approach) risk assessment.			
	1	licies and procedures must be		The facility will progressively develop	specific		l
	reviewed and update	ed at least annually.		policies and update procedures to add	ress the		
	*Additional Requirer	ments for PACE and ESRD		development and maintenance of a prim alternate communication plan.	ary and		l
	Facilities:						
	*[For PACE at §460	.84(b):1 Policies and		The facility will develop policies and pro relative to the management of medi			
	procedures. The PA	CE organization must		nonmedical emergencies.	vai allu		
		nent emergency preparedness		Staff will be trained on policies and pro	redures		
	policies and procedu	ures, based on the forth in paragraph (a) of this		relative to emergency preparedness pla			
	section, risk assessi	ment at paragraph (a)(1) of		Responsible Persons: Nova's Lea			
	this section,			Council, Health & Safety Chairpers			
			<u> </u>	Committee, QP, RSS			

PRINTED: 05/24/20 DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR

		APPROVED	APPROVED				
		CENTERS 0938-0391	CENTERS FOR MEDICARE & MEDICAID SERVICES 0938-0391			N(
		Frequen annually	acy/Monitoring: Reviewed at and updated as deemed necess:	least ary.			
	·						
					- 1		

A. BUILDINGCENTERS FOR MEDICARE & MEDICAID S B. WING0938-0391 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD	05/23/2018
NAME OF PROVIDER OR SUPPLIER B. WING0938-0391 STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD	05/23/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD	
135 DAUGHTRY FIELD ROAD	
l i	
DAUGHTRY FIELD ROAD GROUP HOME MOUNT OLIVE, NC 28365	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION DATE
DEFICIENCY)	
E 013	7-21-18
Continued From page 2 and the communication	
plan at paragraph © of this section. The policies	
and procedures must address management of	
medical and nonmedical emergencies, including,	
but not limited to: Fire; equipment, power, or	
water failure; care-related emergencies; and	
natural disasters likely to threaten the health or	
safety of the participants, staff, or the public. The	
policies and procedures must be reviewed and	
updated at least annually.	
*[For ESRD Facilities at §494.62(b):] Policies and	
procedures. The dialysis facility 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. These	
emergencies include, but are not limited to, fire, equipment or power failures, care-related	
emergencies, water supply interruption, and	
natural disasters likely to occur in the facility's	
geographic area.	
This STANDARD is not met as evidenced by:	
Based on document review and interview, the	
facility failed to ensure policies and procedures	
were developed and updated based the facility's	
emergency preparedness (EP) plan. The finding	
is:	
The facility's EP plan did not include current	
policies and procedures.	
policies and procedures.	
Review on 5/22/18 of the facility's EP plan dated	
9/1/95 (revised 5/15/99, updated 12/26/02) did	
not include current policies and procedures	
regarding the emergency plan, risk assessment	
and communication plan.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPA FOR MEDICARE & MEDICAID SERVICE A. BUILDING CENTERS FOR MEDICARE & MEDICAID SERVICE B. WING 0938-0391 O5/2 NAME OF PROVIDER OR SUPPLIER DAUGHTRY FIELD ROAD GROUP HOME (X2) MULTIPA FOR MEDICARE & MEDICAID SERVICE B. WING 0938-0391 STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365 (X4) ID PROVIDER'S PLAN OF CORRECTION	CES OMB N 23/2018 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER DAUGHTRY FIELD ROAD GROUP HOME B. WING	(X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365	(X5) COMPLETION
DAUGHTRY FIELD ROAD GROUP HOME MOUNT OLIVE, NC 28365	COMPLETION
<u> </u>	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
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TAG REGULATORY OF LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	***************************************
DEFICIENCY)	
E 013	
Continued From page 3	
Interview on 5/23/18 with the Qualified Intellectual	
Disabilities Professional (QIDP) indicated the	
facility was in the process of developing and updating policies and procedures for their EP	
plan; however, none had been completed as of	
the date of the survey.	
E 030 Names and Contact Information E 030 Names and Contact Information	7-21-18
CFR(s): 483.475@(1) CFR(s): 483.475@(1)	
© The [facility, except RNHCls, hospices, The facility will update the current emergency	
transplant centers, and HHAs] must develop and preparedness communication plan with primary	
maintain an emergency preparedness and alternate means of communication.	
communication plan that complies with Federal, State and local laws and must be reviewed and	
State and local laws and must be reviewed and	
updated at least attitudity. The communication	
plan must include all of the following: Staff will be trained on the updated emergency communication plan.	
(1) Names and contact information for the	
following: Responsible Persons: Nova's Leadership	
(i) Staff. Council, Health & Safety Chairperson and	
(ii) Entities providing services under Committee, QP, RSS	
arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.	
Frequency/wonitoring: Heviewed annually	
*[For RNHCls at §403.748©:] The communication and updated as deemed necessary.	
plan must include all of the following:	
(1) Names and contact information for the	i
following: (i) Staff.	1
(i) Staff. (ii) Entities providing services under arrangement.	
(iii) Next of kin, guardian, or custodian.	
(iv) Other RNHCls.(v) Volunteers.	
*!5 AOO1 0440 45@1.Th	
*[For ASCs at §416.45©:] The communication	

	I OF CORRECTION IDENTIFICATION NUMBER:		APPENTATION	COMPLETED	-FO
		A. BUILDING	CENTERS FOR MEDICARE & MEDICA	D SERVICES OM	ВΝ
		B. WING	0938-0391		
NAME OF D	34G319	<u> </u>	OTDEET ADDRESS SITV STATE 719 SODE	05/23/2018	4
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1
DAUGHTRY FIELD ROAD GROUP HOME			135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365		
			WOONT CLIVE, NC 28303		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	(X5) COMPLETION	7
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	DATE	- -
			DEFICIENCY)		١
E 030		E 03	30		-
,				·	
	Continued From page 4 plan must				İ
	include all of the following:				
	(7) Names and contact information for the				
i	following:	1			
	(i) Staff.				
	(ii) Entities providing services under arrangement.				
	(iii) Patients' physicians. (iv) Volunteers.				
	*IFor Licenians at \$410,1100 The communication				
	*[For Hospices at §418.113l:] The communication plan must include all of the following:				
	(1) Names and contact information for the				
	following:				
	(i) Hospice employees.				ł
	(ii) Entities providing services under arrangement.				l
	(iii) Patients' physicians. (iv) Other hospices.				
	*[For OPOs at §486.360l:] The communication plan				1
	must include all of the following:				
	(1) Names and contact information for the following:				
	(i) Staff.				
	(ii) Entities providing services under arrangement.				
	(iii) Volunteers.				
	(iv) Other OPOs.				
	(v) Transplant and donor hospitals in the OPO's				
	Donation Service Area (DSA).				
	This STANDARD is not met as evidenced by: Based on document review and interview, the				
	facility failed to ensure an emergency				
	preparedness (EP) communication plan was				1
	developed and maintained in compliance with				
	Federal, State and local laws. The finding is:				
	The facility's EP plan did not include a				
	communication plan.				
	D				
L	Review on 5/22/18 of the facility's disaster plan				┙

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	DEPARTMENT OF HEALTH AND HUMA以為成 PAFFANSTERCTION CO	FINE SUPPLIES FO
		34G319	A. BUILDIN	^{IG} CENTERS FOR ME DICARE & MEDICAID SE -0938-0391	
	ROVIDER OR SUPPLIER RY FIELD ROAD GROU			STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365	7.07.20.7.0
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	5/15/99, updated 12/communication plan contact information plan contact information for physicians, and othe Interview on 5/23/18 Disabilities Profession facility is in the proceduced developing their EP proceduced in the proceduced facility is in the proceduced facility is in the proceduced facility is in the proceduced facilities with the old plep Training Program CFR(s): 483.475(d)(1) (7) Training program ASCs, PACE organd dialysis facilities (i) Initial training policies and proceduced facilities facilities (ii) Provide emetat least annually. (iii) Provide emetat least annually. (iii) Maintain document facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities facilities fa	or staff, guardians, r facilities and/or entities. with the Qualified Intellectual and (QIDP) revealed the less of updating and colan and are aware of the lean. In the [facility, except CAHs, ganizations, PRTFs, Hospices, I must do all of the following: g in emergency preparedness res to all new and existing	EC	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 Leadersl Council, Health & Safety Chairperson a Committee, QP, RSS Frequency/Monitoring: Initially, annually, a as deemed necessary.	nd

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPA	DEPARTMENT OF HEALTH AND HUMA FAMILE OF HEALTH AND HUMA		BURVEY LETED	F	OF
			A. BUILD	NG _	CENTERS FOR MEDICARE & MEDICA	D SERV	ICES	OMB	N
		246210	B. WING	-05	938-0391		23/2018		ĺ
NAME OF P	ROVIDER OR SUPPLIER	34G319		s	TREET ADDRESS, CITY, STATE, ZIP CODE	007	23/2010	'	
				1:	35 DAUGHTRY FIELD ROAD				
DAUGHT	RY FIELD ROAD GROUP	PHOME		N	OUNT OLIVE, NC 28365				l
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLE		l
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					DEFICIENCY)				l
E 037			E	037	·				ĺ
	Continued From page	e 6							
	(iii) Maintain docume	ntation of the training. (iv)							
·	•	owledge of emergency							
	procedures.								
	*[For Hospices at §4	18.113(d):] (1) Training. The							
	hospice must do all o	•							
		g in emergency preparedness res to all new and existing							
		and individuals providing							
		gement, consistent with their			•				
	expected roles.								
	(ii) Demonstrate procedures.	e staff knowledge of emergency							
	1 *	rgency preparedness training							
	at least annually.								
	1 ' '	review and rehearse its							
		ness plan with hospice g nonemployee staff), with							
		ced on carrying out the							
		y to protect patients and others.							
	*!CDDTC: 0444	404/4N-1 (4) T							
	*[For PRTFs at §441	.184(d):] (1) Training must do all of the following:							
	_	nergency preparedness							
	policies and procedu	res to all new and existing							
	staff, individuals prov								
	expected roles.	lunteers, consistent with their							
	•	aining, provide emergency							
	preparedness training								
	(iii) Demonstrate procedures.	e staff knowledge of emergency							
	-	cumentation of all emergency							
	preparedness training								
	*FF DAGE - 10455	D4/4\174\TI D4 CT							
	*[For PACE at §460.8 organization must do	84(d):] (1) The PACE							
	organization must do	an or the following.							
I			1				1		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		III'A	DEPARTMENT OF HEALTH AND HUMA SERVITEBOTION	COMPI	ETED	
			A. BUILDI	NG _	CENTERS FOR MEDICARE & MEDICA	D SERVI	CES	OM
		34G319	b. Wild	05	938-039 	05/2	23/2018	3
	ROVIDER OR SUPPLIER RY FIELD ROAD GROU	P HOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 35 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365			
(X4) ID PREFIX ——TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED-TO-THE-APPROPRI DEFICIENCY)		(X5) COMPLE ——DAT	TION
E 037			F	037				
_ 00.	Continued From pag	ie 7		007	·			
	(7) Initial training in policies and pro existing staff, in services under a participants, and their expected repreparedness tr (iii) Demonstrate procedures, includint to do, where to go, a an emergency.	emergency preparedness cedures to all new and dividuals providing on-site arrangement, contractors, d volunteers, consistent with oles. (ii) Provide emergency raining at least annually. e staff knowledge of emergency g informing participants of what and whom to contact in case of cumentation of all training.						
	CORF must do all of initial training in emergency procedurations. (ii) Maintain do training. (iv) Demons emergency procedure be oriented and assiregarding the CORF weeks of their first was must include instructional arm systems and sequipment.	ergency preparedness						
	The CAH must do al (i) Initial training in e policies and procedu reporting and exting							

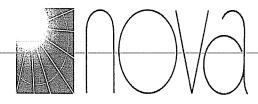
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		"PAPPI	PARTMENT OF HEALTH AND HUMP RUSTEBOTION	COMP	LETED	FIC
			A. BUILDIN B. WING _	NG CE 0938	ENTERS FOR MEDICARE & MEDICAL	D SERV	ICES	OMB
		34G319				05/	23/2018	в
	NAME OF PROVIDER OR SUPPLIER DAUGHTRY FIELD ROAD GROUP HOME			135	EET ADDRESS, CITY, STATE, ZIP CODE DAUGHTRY FIELD ROAD UNT OLIVE, NC 28365		,	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5	i)
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E 037		·	ΕC	037				
	Continued From page	ge 8 personnel, and guests,						
		cooperation with firefighting						1
	•	ties, to all new and existing						
		•						
	· -	viding services under						
	· ·	olunteers, consistent with						
	their expected roles.							
	1 ' '	ergency preparedness						1
	training at least annu							
	(iii) Maintain do	cumentation of the						
	training.(iv) Demons	trate staff knowledge of						
	emergency procedu	res.						
	CMHC must provide preparedness policic and existing staff, in under arrangement, with their expected r documentation of the demonstrate staff kn procedures. Thereaf emergency prepared annually. This STANDARD is Based on interview failed to ensure directions.	e training. The CMHC must nowledge of emergency fter, the CMHC must provide dness training at least and met as evidenced by: and record review, the facility ct care staff were adequately e facility's emergency						
	Staff interviews (2) of been trained regardi	ed EP training as indicated. on 5/23/18 revealed they have ing monthly fire/disaster drills;						
	details regarding the	ould not provide specific e facility's EP program.		HALF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPE				
		on 5/23/18 with the Qualified es Professional (QIDP)						

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPA	SERNSTERION	PIDATE BUIEVEY HOP COMPLETED
PROVIDER OR SUPPLIER	34G319	A. BUILDING	CENTERS FOR MEDICARE & MEDICAID \$ 938-0391	SERVICES OMB N 05/23/2018
	P HOME	1	35 DAUGHTRY FIELD ROAD	
		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
,		TAG		DATE
Continued From page received training on EP plan as the plan updated. Further interview on revealed they were plant staff on the facility's plan; however, the training PROGRAM IMPLEM CFR(s): 483.440(d)(d). As soon as the interformulated a client's each client must receive treatment program of interventions and seand frequency to sure objectives identified plan. This STANDARD is Based on observation review, the facility fainteractions between the implementation (IPP) in the area of	the facility's most current was in the process of being 5/23/18 with the QIDP preparing to train direct care most current emergency raining not been completed. MENTATION (1) disciplinary team has individual program plan, erive a continuous active consisting of needed ervices in sufficient number pport the achievement of the in the individual program not met as evidenced by: ons, interviews and record alled to ensure a pattern of a clients and staff supported of individual program plan diet/menus. This affected 1 of		CFR(s): 483.440(d)(1) Nursing will consult with Physician to de clear guidelines for staff to ensure a concise, and consistent profimplementation. Clear guidelines for a consumers that are following two or more orders will be available for staff reference direction. QP and RSS will ensure that staff are profit trained according to those guidelines proper implementation. Responsible Staff: Nursing, QP, RSS	clear, gram those e diet e and perly and
Client #3's diet was with current menus. During breakfast ob 5/23/18 at 7:58am, opacket of flavored oslice of toast, juice,	not followed in accordance servations in the home on client #3 served himself one atmeal, one boiled egg, one milk and water. At 8:02am,			
	Continued From page received training on EP plan as the plan updated. Further interview on revealed they were pateff on the facility's plan; however, the training on EPROGRAM IMPLEN CFR(s): 483.440(d)() As soon as the interformulated a client's each client must receive treatment program of interventions and seand frequency to sure objectives identified plan. This STANDARD is Based on observation review, the facility fainteractions between the implementation (IPP) in the area of 3 audit clients (#3). Client #3's diet was with current menus. During breakfast ob 5/23/18 at 7:58am, packet of flavored or slice of toast, juice,	TRY FIELD ROAD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 revealed staff have not received training on the facility's most current EP plan as the plan was in the process of being updated. Further interview on 5/23/18 with the QIDP revealed they were preparing to train direct care staff on the facility's most current emergency plan; however, the training not been completed. 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 ensure a pattern of interactions between clients and staff supported the implementation of individual program plan (IPP) in the area of diet/menus. This affected 1 of 3 audit clients (#3). The finding is: Client #3's diet was not followed in accordance	PROVIDER OR SUPPLIER TRY FIELD ROAD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIZATORY OR LSC IDENTIFYING INFORMATION) TAG Continued From page 9 revealed staff have not received training on the facility's most current EP plan as the plan was in the process of being updated. Further interview on 5/23/18 with the QIDP revealed they were preparing to train direct care staff on the facility's most current emergency plan; however, the training not been completed. 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 ensure a pattern of interactions between clients and staff supported the implementation of individual program plan (IPP) in the area of diet/menus. This affected 1 of 3 audit clients (#3). The finding is: Client #3's diet was not followed in accordance with current menus. During breakfast observations in the home on 5/23/18 at 7:58am, client #3 served himself one packet of flavored oatmeal, one boiled egg, one slice of toast, juice, milk and water. At 8:02am,	PROVIDER OR SUPPLIER TRY FIELD ROAD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (RACH DEPICIENCY MIST BE PRECEDED BY PLUL. REQUIZING YM STATEMENT OF DEFICIENCIES (RACH DEPICIENCY MIST BE PRECEDED BY PLUL. REQUIZING YM STATEMENT OF DEFICIENCIES (RACH DEPICIENCY MIST BE PRECEDED BY PLUL. REQUIZING YM STATEMENT OF DEFICIENCIES (RACH DEPICIENCY MIST BE PRECEDED BY PLUL. 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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPA	PERMITTED HEALTH AND HUM,		BUANEY LETED	FO
			A. BUILD	ING	CENTERS FOR MEDICARE & MEDICA	ID SERV	ICES OMI	BN
		34G319	B. WING	0	938-0391		23/2018	
NAME OF P	ROVIDER OR SUPPLIER	04010	<u> </u>	Ī .	STREET ADDRESS, CITY, STATE, ZIP CODE	1 007	20,2010	1
DAUGHTF	RY FIELD ROAD GROUF	HOME			135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	ïY	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	ıc	(X5) COMPLETION	1
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRI		DATE	1
W 249			W	249				-
	Continued From page 10						•	
	slice of toast to which he added "I Can't Believe It's Not Butter" spray.							
	Review on 5/23/18 of the breakfast menu indicated the following:							
	Low calorie, 1500 cal	orie menu						
	Orange/Pineapple juice 1/2 c Plain oatmeal 1/2 c Egg (any style) 1 each Toast 1 slice (no margarine) Skim milk							
	Low cholesterol menu	u						
	Orange/Pineapple jui Oatmeal (any flavor) Egg beaters 1 serving Toast 2 slices with m Skim milk	1/2 c g						
	orders dated 5/1 - 5/3 assessment dated 2/3 for a low calorie 1500 family style diet with I snacks. The nutrition low-calorie diet preso remains appropriate 1 [Client #3's] low chole	f client #3's physician's 31/18 and nutrition 9/18 revealed a diet order 0 calorie, low cholesterol low calorie, low cholesterol n assessment noted, "His cribed to promote weight loss for promoting weight loss. esterol diet modifications ssist medication in lipid						
	consumes a low calo cholesterol diet. The	n 5/23/18 revealed client #3 rie 1500 calorie and a low staff indicated they 500 calorie menu at meals.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	DEPARTMENT OF HEALTH AND HUMANSSEARE TIPAF FROM COMP	BURNEY HOR
		34G319	A. BUILDI	NG CENTERS FOR MEDICARE & MEDICALD SERV 0938-0391	
	ROVIDER OR SUPPLIER	 		STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365	23/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY-OR-LSG-IDENTIFYING-INFORMATION)			PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED-TO-THE-APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	sizes from the low-caitems from the low charitems from the low charitems from the low charitems from the low charitems from the low charified for staff. DRUG ADMINISTRACFR(s): 483.460(k)(1) The system for drug that all drugs are admitted the physician's orders. This STANDARD is respectively failed the physician's orders. This STANDARD is respectively failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed the facility failed th	with nursing staff (2) full receive certain portion alorie menu and certain food holesterol menu. The ledged using both menus for infusing and this needed to ATION (1) administration must assure ininistered in compliance with is. Interviews and record led to ensure medications accordance with physician's accordance with physician's if 1 of 3 clients observed is (#6). The finding is: Interviews and record led to ensure medications accordance with physician's accordance with physician's if 1 of 3 clients observed is (#6). The finding is: Interviews and record led to ensure medications accordance with physician's accordance with physician's if 1 of 3 clients observed is (#6). The finding is: Interviews and record led to ensure medication accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accordance with physician's accord	Wa	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The facility will administer drugs in compliance with physician orders. Staff will be in-serviced/trained on drug administration process and administering medications according to physician orders. Responsible Persons: QP and RSS Frequency: Initial, Annual, and as deemed necessary.	7-21-18

STATEMENT OF DEFICIENCING AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPA F FRUSTELECTION					OR
	34G319		346310	A. BUILDING —CENTERS FOR MEDICARE & MEDICA B. WING —0938-0391			AID SERVICES OMB 05/23/2018		NO	
	NAME OF PR	ROVIDER OR SUPPLIER	344313		S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	23/2010		
DAUGHTRY FIELD ROAD GF			HOME	135		B5 DAUGHTRY FIELD ROAD OUNT OLIVE, NC 28365				
			SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTIO		BE COMPLET		TON	
	——TAG——	REGULATORY-OR-LSG-IDENTIFYING-INFORMATION)		TAG		CROSS-REFERENCED-TO-THE-APPROPRIM DEFICIENCY)	ATE.	DATE		
	W 368	368 Continued From page 12		W 368						
		Azulfidine (Sulfasalazine) tab 500mg, two by mouth four times a day take within 20 minutes of meal or snack.								
			with nursing staff confirmed ingested the medication as sian.						,	



BEHAVIORAL HEALTHCARE CORPORATION

.....lighting the way to new beginnings

Thursday, May 31, 2018

Wilma Worsley-Diggs, M.Ed., QIDP Facility Compliance Consultant I Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

DHSR - Mental Health

JUN 07 2018

Lic. & Cert. Section

Re:

Recertification Survey

Facility:

Daughtry Field Road Group Home

Provider Number::

34G319

MHL:

096-037

Dear Ms. Worsley-Diggs,

We, Nova, IC., truly appreciate you for conducting our annual survey at our Daughtry Field Road group home. We appreciate your input and level of expertise; we always take surveys as an opportunity to learn, grow, and make improvements for the wellbeing of the population we serve. Thank you for all that you do to ensure efficiency, quality, and growth.

Furthermore, I, Candra Hill, Program Director, received a copy of the Statement of Deficiencies on May 26th, 2018 via e-mail. I have attached the Plan of Correction for Nova, IC.'s Daughtry Field Group Home located at 135 Daughtry Field Rd., Mt. Olive, NC 28365.

Should you have questions, comments, or concerns, please feel free to contact me at your earliest convenience at <u>candrahill@nova-ic.org</u> or via phone at (919) 734-8803 ext. 1014 or via cell at (919) 738-3814.

ery Respectfylly,

Candra Hill

Program Director, MSW, LCSW-A

Nova, IC.