PRINTED: 05/11/2018
FORM APPROVED
OMB NO. 0938-0391

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
	34G307	A. BUILDING _____ B. WING _____	05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLEA GROUP HOME	5691 MACK LINEBERRY ROAD CLIMAX, NC 27233

(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 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure an acceptable risk assessment was performed to address and identify hazards (e.g. natural, man-made, facility, geographic, etc.) in the facility's emergency plan (EP). The finding is:	E 004	E004 The facility will develop a comprehensive emergency preparedness plan that meets the requirements including a risk assessment. The plan will be reviewed at least annually and updated. Staff will be inserviced on the emergency plan at least annually. QP/Program Manager will monitor monthly and update plan at least annually. DHSR - Mental Health JUN 11 2018 Lic. & Cert. Section	6/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: COO | (X6) DATE: 6/11/18

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 004	Continued From page 1 The EP risk assessment was not performed. Review on 5/1/18 of facility documents revealed the following: There was no risk assessment completed to address and identify hazards (e.g. natural, man-made, facility, geographic, etc.) for the facility. During an interview on 5/2/18 with the qualified intellectual disabilities professional (QIDP) revealed he was not aware of the need to perform a risk assessment. Additional interview on 5/2/18 with the facility administrator revealed the agency was not aware of what the actual structure of the EP or how it was to be developed.	E 004		
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(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:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans."* *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure an acceptable risk assessment	E 007	E007 The facility will develop a comprehensive emergency preparedness plan that meets the requirements including a risk assessment. The plan will address the following: population served, type of service provided, and ability to provide service in the event of an emergency. The plan will be reviewed at least annually and updated. Staff will be inserviced on the emergency plan at least annually. QP/Program Manager will monitor monthly and update plan at least annually.	6/30/18

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E 007	Continued From page 2 was performed to address the needs of the population served in the facility's emergency plan (EP). The finding is: The EP risk assessment was not specific to the needs of the client population. Review on 5/1/18 of facility documents revealed the following: A training for fire and tornado drills and the evacuation procedures. There was no risk assessment available specific to the at-risk client population at the facility. During interviews (3) on 5/2/18 with the qualified intellectual disabilities professional (QIDP) and the facility administrator (via phone) revealed they were not aware of the risk assessment to address the specific needs of the facility population.	E 007		
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.	E 032	E032 The facility will develop and maintain an emergency preparedness plan that is reviewed and updated annually. The plan will address primary and alternate means of communicating with staff, emergency management agencies, and oversight agencies. The facility will identify primary and alternate means of communication and inservice staff. QP/Program Manager will monitor plan monthly to ensure that the needs/strategies are accurately identified and addressed.	6/30/18

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E 032	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency. Review on 5/1/18 of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication. During an interview on 5/2/18, management revealed if the land line phone and cell service were down there was not another way to communicate during an emergency.	E 032	E036	6/30/18
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	E 036	The facility will develop and maintain an 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 strategies for addressing identified risks/client's needs. Facility will inservice staff on identified emergency preparedness plan. QP/Program Manager will monitor plan monthly to ensure that the needs/strategies are accurately identified and addressed.	

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E 036	Continued From page 4 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 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 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 5/1/18/18 of the facility's EP manual, it did not include any information on training or testing for the staff. During an interview on 5/2/18, staff revealed they had not been tested on the EP and they could only provide the training for fire and tornado drills.	E 036		

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E 036	Continued From page 5 During an interview on 5/1/18, the qualified intellectual disabilities professional (QIDP) confirmed there was no documentation for staff training or tesing regarding the EP.	E 036		
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 observations, and interviews the facility failed to ensure the rights and dignity for 1 of 3 audit clients (#3) related to the use of incontinence pad on the chair. The finding is: Client #3 was only allowed to sit on the furniture with the use of incontinence padding. During observations at the home on 5/1-2/18, client #3 sat on the chair with an incontinence pad positioned underneath him. The pad was exposed and visible to anyone in the home. During an interview on 5/2/18, staff revealed client #3 uses incontinence pads on the seats to, "protect the seat in case the client urinate and the urine runs out of the pull-up." Review on 5/2/18 of client #3's individual program plan (IPP) dated 12/6/18 revealed, "Goes to the toilet alone and urinates; Partial Independence." During an interview on 5/2/18, with the qualified intellectual disabilities professional (QIDP)	W 125	W125 The facility will ensure the rights of all clients. The facility will ensure that incontinent individuals will have their rights respected at all times. Staff will be inserviced on how to handle incontinent individuals and padding to ensure that all rights are maintained. QP/Program Manager will monitor weekly to ensure rights of all clients are being respected.	6/30/18

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W 125	Continued From page 6 confirmed the pads are use for sanitary reasons, "Client #3 sometimes can urinate and it can run through the pull-up." The QIDP also acknowledged the use of incontinence pads in this manner could be a violation of client #3's right to dignity and privacy.	W 125		
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, record reviews and interviews, the facility failed to ensure 1 of 3 audit clients (#3) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the area of adaptive equipment use. The finding is: Client #3's adaptive bowl guard was not used as indicated. During lunch observations at the day program on 5/2/18, client #3 did not use a bowl guard. Review on 5/2/18 of client #3's IPP dated 4/18/17 revealed, "[Client #3]...current adaptive equipment to promote function and minimize	W 249	W249 The facility will ensure that each client receives an individualized, continuous active treatment plan with identified interventions and services. All staff will be inserviced on use of adaptive equipment needed to promote independence. QP/Program Manager will monitor weekly.	6/30/18

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W 249	Continued From page 7 spillage...deeper bowl and guard." Durina an interview on 5/2/18 with the QIDP revealed client #3 should use bowel guard as indicated in the IPP	W 249		
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 ensure 2 of 3 audit clients (#3, # obtained an annual physical evaluation including evaluation of their vision and hearing. The findings are: 1. Client #3 did not receive an annual vision screening. Review on 5/2/18 of physical examination reports for client #3 dated 9/27/17, did not include a screening of his vision. Additional review of the client's record did not indicate a vision screening had been completed. During an interview on 5/2/18 with the qualified intellectual disabilities professional (QIDP) confirmed the client #3 had not been assessed for his vision. 2. Clients #5 did not receive an annual hearing screening. Review on 5/2/18 of physical examination reports	W 323	W323 The facility will ensure that each client receives an annual physical examination which includes evaluation of hearing and vision. All clients will receive an annual physical examination including evaluation of hearing and vision. Nurse and QP will monitor monthly.	6/30/18

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W 323	Continued From page 8 for client #5 dated 3/10/17, did not include a screening of the client's hearing. Additional review of the client's record did not indicate a hearing screening had been completed. During an interview on 5/2/18 with the QIDP confirmed the client #5 had not been assessed for his hearing. During an interview on 5/2/18, the nurse confirmed client #5's annual hearing screening should have been completed. 3. Client #5 did not receive an annual physical. Review on 5/2/18 of client #5's current record revealed an annual physical examination dated 3/10/17. There was no current information available for review to indicate client #5 has received an annual physical examination since. During an interview on 5/2/18, the nurse confirmed client #5's annual physical examination should have been completed.	W 323		
W 324	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(ii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the	W 324	W324 The facility will ensure that each client receives an annual physical examination which includes immunizations. Nurse will obtain immunization records on all clients. Nurse and QP will monitor monthly.	6/30/18

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W 324	Continued From page 9 facility failed to ensure immunization records for 1 audit client (#5) had been obtained. The finding is: Client #5's records did not include his past immunization history. Review on 5/2/18 of client #5's record revealed he had been admitted to the facility on 11/14/97. Additional review of the record indicated the client had received annual influenza and tuberculin testing "Tetanus" on 8/27/08; however, no history of other past immunizations was located. During an interview on 5/2/18, the facility nurse confirmed client #5's immunization history was not current.	W 324		
W 325	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure lab work was obtained as ordered by the physician for 1 of 3 audit clients (#3). The finding is: Lab work for client #3 was not obtained as ordered. Review on 5/2/18 of client #3's current physician's order revealed the following: "L1. Annual CBC w	W 325	W325 The facility will ensure that each client receives an annual physical examination which includes routine laboratory screenings as indicated by the physician. Nurse will ensure that all clients ordered laboratory screenings are obtained as indicated by the physician. Nurse and QP will monitor monthly.	6/30/18

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W 325	Continued From page 10 Diff, TSH, CMP. EVERY Jan. L2. Vit D leevel due with annual labs....L5. d/t Tegretol, Tegretol level, CBC w Diff every 6 months in Jan and Jul...." Additional review of client #3's ordered medications revealed Tegretol 200mg: Take (2) tablets by mouth three times daily. Further review on 5/2/18 of client #3's current record revealed the most recent labs dated 3/3/17. During an interview on 5/2/18, the nurse confirmed client #3's current record did not have any more recent labs.	W 325		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, policy review and interviews, the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This affected all clients residing in the home. The finding is: Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination. During observations on 5/1/18 in the home at approximately 6:48 pm, staff walked client #3 to his room. Shortly after, client #3 came out of the room holding dirty pants in one hand and dirty pull-up in the other hand. Client #3 was then	W 454	W454 The facility will provide a sanitary environment to avoid sources and transmission of infections. Staff will be inserviced on how to promote handwashing throughout the daily routine. QP/Program Manager will monitor weekly.	6/30/18

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W 454	Continued From page 11 directed to the laundry room where he disposed his dirty diaper and put the dirty pants in a humper. Client #3 proceeded to the dayroom and retrieved a basket with blocks in it. Client #3 started playing with the block and the staff proceeded to another part of the house. At no time was client #3 prompted to wash in his hands. During an interview on 5/1/18, staff confirmed they are suppose to encourage the client to wash his hands after touching dirty pull-up. Review on 5/2/18 of the client #3's adaptive behavior inventory (ABI) dated 12/6/17 revealed client #3 is partially independent on washing hands after toileting. During an interview on 5/2/18, the facility's nurse revealed staff are to prompt clients to wash hands when they come into contact with any bodily fluids.	W 454		