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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 record review and interview, the facility failed to develop an emergency preparedness (EP) plan including the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. The finding is:	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 The facility did not have an emergency plan based upon risk assessments. Review on 6/25/18 of the facility's current EP plan revealed the plan did not provide specific information in regards to the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. Interview on 6/26/18 with the qualified intellectual disabilities professional (QIDP) revealed they were aware of this and are working to correct this issue with the EP plan.	E 006		
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 assure an acceptable risk assessment was performed to address the needs of the population served in the facility's emergency plan (EP). The finding is:	E 007		

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E 007	Continued From page 2 The EP risk assessment was not done specific to the needs of the client population. Review on 6/25/18 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. Interviews (2) on 6/26/18 with the qualified intellectual disabilities professional (QIDP) and home manager revealed they were not aware of the risk assessment to address the specific needs of the facility population.	E 007		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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	E 013		

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E 013	Continued From page 3 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 interview, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk assessment and their communication plan in case of an emergency evacuation of the clients in the facility. The finding is: During an interview on 6/26/18, with management revealed they did not have policies and procedures specifically for the emergency preparedness plan. However, they have been working to develop these policies and procedures.	E 013		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3)	E 032		

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E 032	Continued From page 4 [(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 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 6/25/18 of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication. During an interview on 6/26/18, management revealed if the land line phone and cell service were down they were not aware of another way to communicate during an emergency.	E 032		

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E 036	Continued From page 5	E 036		
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 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	E 036		

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E 036	Continued From page 6 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 6/25/18 of the facility's EP manual, it did not include any information on training or testing for the staff. During interviews on 6/25/18 and 6/26/18, (3) 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 6/26/18, the qualified intellectual disabilities professional (QIDP) confirmed there was no documentation for staff training or testing regarding the EP.	E 036		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually.	E 037		

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(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness

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policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented

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and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility

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E 037	Continued From page 10 failed to assure direct care staff were sufficiently trained on the facility's emergency plan (EP). The finding is: Staff had not received adequate training on the emergency plan (EP). Review on 6/25/18 of facility documents revealed training inservice sheets for direct care staff in regards to fire drills and disaster. Staff interviews (2) on 6/25/18 revealed the following; staff were able to provide the procedures regarding fire drills and disaster drills; however, the staff could not provide specific details regarding any training they received for the facility's EP program. Interview on 6/26/18, with the qualified intellectual disabilities professional (QIDP) revealed he did not have any training for direct care staff specific to the facility's EP.	E 037		
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, interviews and record	W 249		

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review, the facility failed to assure 2 of 4 audit clients (#4 and #6) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the area of behavior management, medication administration participation, adaptive equipment use and implementing physician's orders. The findings are:

1. Client #4's behavior support guidelines were not implemented as written.

During observations in the home on 6/25/18, client #4, was in his wheelchair (self propelled) throughout the home freely. Client #4, moved to the table and sat there he hit the table with his hand once and slapped himself 4, times the slaps could be heard. There was (1) staff sitting at the table when these incidents occurred at no time did the staff respond.

Additional observations in the home on 6/26/18, revealed client #4, sitting in his wheelchair self propelled himself from the living room to the dining table. During his movement from the living room to the dining table he slapped himself 5, times. Client #4, sat at the dining table and waited for breakfast he hit his hand on the table once and slapped himself in the face 8, times. There were (2) staff present when these incidents occurred at no time did the staff respond

Review on 6/26/18 of client #4's record revealed, behavior support guidelines dated 12/21/17, revealed the following instructions "Self-injurious Behavior: Any behavior that could result in harm to self (for example hitting his elbows and hands on the table, hitting himself in the face etc.). 1.

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Direct [Client #4] to stop the behavior and encourage him to engage in a calming act such as taking deep breaths."

Staff (2) interview on 6/25/18 revealed client #4, has behavior support guidelines and they should attempt to redirect him when he hits himself.

Interview on 6/26/18, with the qualified intellectual disabilities professional confirmed client #4's behavior support guidelines should have been followed as written.

2. Client #4 was not afforded the opportunity to consistently display his independence with eating during his medication administration.

During observations on 6/26/18 of client #4's medication administration pass at approximately 8:00am, obtained his medications, obtained the pill packets, shook Cinnamon applesauce into a medication cup, sprinkled the crushed pill powder into the applesauce and spoon fed it to client #4 from the medication cup while using a regular disposable spoon. Client #4 was not offered nor encouraged to feed himself during this process. Client #4 was only given the opportunity to assist with punching his pills. Client #4 was not offered nor encouraged to dispose of his trash. Client #4 was observed to independently feed himself during all of his meals.

Review on 6/26/18 of client #4's medication administration adaptive behavior inventory (ABI) dated 3/1/17 revealed, "Places pill in mouth...Disposes of trash with assistance."

During an interview on 6/26/18, the medication

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technician confirmed the clients do not use their adaptive spoons or any devices when they are taking their medications. Further interview confirmed, "No, the clients' do not feed themselves [during the med administration], they might spill it and get it all over their clothes."

3. Client #6 was not afforded the opportunity to consistently display her independence with eating during her medication administration.

During observations on 6/26/18 of client #6's medication administration pass at 8:14am, staff obtained her medications, obtained the pill packets, shook Cinnamon applesauce into a medication cup, sprinkled the crushed pill powder into the applesauce and spoon fed it to client #6 from the medication cup while using a regular disposable spoon. Client #6 was not offered or encouraged to feed herself during this process. The staff disposed of client #6's trash as client #6 looked on. Client #6 was not offered nor encouraged to dispose of her trash. Client #6 was only given the opportunity to assist with punching her pills.

During dinner and breakfast observation in the home on 6/25 -26/2018, client #6 was observed to independently feed herself during all of her meals.

Review on 6/26/18 of client #6's IPP dated 12/28/17 revealed, "[Client #6's] strengths in dining skills are: Dines with minimal assistance....Participates in family style dining...."

Review on 6/26/18 of client #6's adaptive behavior inventory (ABI) dated dated 2/7/18 revealed, "Eats with spoon with minimal spillage

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	34G044	A. BUILDING _____ B. WING _____	06/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH AVENUE HOME	105 EAST HEATH AVE SMITHFIELD, NC 27577

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W 249	Continued From page 14 Total independence...." Review on 6/26/18 of client #6's medical ABI dated 2/7/18 revealed, "Disposes of trash....States name of medication, States purpose of medication...Partial Independence Strength at potential." Further review of the medical ABI revealed, "States possible side effects of medication Partial Independence N = A skill that can be considered for training." During an interview on 6/26/18, the medication technician confirmed the clients do not use their adaptive spoons or any devices when they are taking their medications. Further interview confirmed, "No, the clients' do not feed themselves [during the med administration], they might spill it and get it all over their clothes." During an interview on 6/26/18, the QIDP confirmed the client's. adaptive equipment should have used and integrated during the med administration And if they eat independently or hand-over-hand they are to use their adaptive equipment to do that. 4. Client #6 did not use her adaptive device during her dinner and breakfast meals. During breakfast observations in the home on 6/25/18 at 9:14am, client #6 ate her breakfast using a low plate riser tray, regular plate, regular spoon, rocker knife along with wearing a clothing protector. There were no other adaptive eating devices nor mat used by client #6 during this meal. Review on 6/26/18 of client #6's IPP dated 12/28/17 revealed, "Adaptive Equipment:	W 249		

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W 249	Continued From page 15 ...dycem mat and elevated platform." During an interview on 6/26/18, the QIDP confirmed the clients' should have used her adaptive eating equipment during her meals. 5. Client #6's physician's orders were not implemented as written. During observations in the home on 6/25 -26/2018, client #6 wore regular mid calf white crew sock. Client #6 was not observed wearing any other type socks or hose/stockings. Review on 6/26/18 of client #6's physician's orders dated 3/27/18 revealed, "TED MD...BEIGE PUT ON LEGS IN THE MORNING AND REMOVE AT BEDTIME." During an interview on 6/26/18, the QIDP confirmed client #6's physician's orders were current and she should have been wearing her TED hose.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure data was documented for 1 of 3 audit clients (#4). The finding is:	W 252		

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W 252	Continued From page 16 Staff failed to collect data as prescribed for client #4's objective. Review on 6/25/18 of client #4's record revealed the following objective. "HH: [Client #4] will hold his toothbrush with 50% partial physical prompts for four consecutive review periods. Data collection Monday thru Fridays on 1st and 2nd shift." Review client #4's data book revealed following dates had no recorded data available for review 1st shift 6/13/18, 6/14/18, 6/15/18 and 6/24/18 and 2nd shift 6/7/18. During an interview on 6/25/18, staff revealed they are to document on the objective Monday thru Friday on both shifts. During an interview on 6/26/18, the qualified intellectual disabilities professional (QIDP) confirmed the staff are to document on the objective as it written.	W 252		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure all medications were administered without error for 1 of 4 audit clients (#1). The finding is: Client #1's Miralax laxative was administered at	W 369		

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W 369	Continued From page 17	W 369		

the wrong time and another client's nasal spray medication was administered.

a. During observations of the medication administration pass on 6/26/18 at 7:13am, the kitchen staff gave the medication technician an undetermined amount of water in a blue plastic cup for client #1. The medication technician measured 17grams of Miralax using the measuring device from the container and added the Miralax to the undetermined amount of water, stirred and gave it client #1. Client #1 ingested the Miralax and undetermined amount of water.

b. Staff used another client's personal property (nasal spray) on client #1.

During medication administration observations on 6/26/18 at 7:13am, the medication technician administered Calcitonin-Salmon nasal spray medication (1 spray right nostril) to client #1. As the medications were being checked by the surveyor for accuracy, it was identified by the surveyor client #1 was administered nasal spray from a bottle which belong to another client. The nasal spray administered was Calcitonin-Salmon nasal spray the same type medication client #1 receives.

During an interview on 6/26/18, the medication technician confirmed client #1 received another clients Calcitonin-Salmon nasal spray medication. The staff stated they thought it belonged to client #1 since it was on her shelf.

Review on 6/26/18 of client #1's physician's orders dated 3/27/2018 revealed, "Miralax - 17gms PO w/8oz. of liquids at night for Constipation." Further review of client #1's

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W 369	Continued From page 18 physician's orders revealed, "CALCITONIN - SALMON NASAL SPRAY...GIVE 1 SPRAY IN 1 NOSTRIL DAILY **ROTATE NOSTRILS DAILY*...8AM." During an interview on 6/26/18, the qualified intellectual disablilites professional (QIDP) there should not have occurred, if they were doing their three checks. During an interview on 6/26/18, the nurse confirmed client #1's physician's orders were correct and should have been followed. Further interview confirmed client #1 should have received her Miralax at 8pm at night.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, and interviews, the facility failed to assure all drugs and biologicals remained locked until the point of preparation and administration. The finding is: The medications were left unlocked and unsupervised by staff. During observations in the home on 6/26/18, the medications were left unsupervised on several separate occasions, the were clients in the area and the surveyor had access to the medications without staff supervision. Staff left the medications unlocked and unsupervised to	W 382		

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W 382	Continued From page 19 perform tasks such as: to take clients to another area of the home and take/obtain an item(s) to/from another area in the home. During an interview on 6/26/18, the staff confirmed the medication closet should not be left unlocked and unsupervised. During an interview on 6/26/18, the qualified intellectual disabilities professional (QIDP) confirmed the medications and the medication cabinet should not have been left and unsupervised by staff.	W 382		