STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G059	A. BUILDING _____ B. WING _____	05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT GROUP HOME	205 WIMMER CIRCLE BELMONT, NC 28012

(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 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: The facility failed to ensure the emergency plan (EP) was developed and sufficiently maintained relative to individualized information for clients, and supplies of water and food as evidenced by observations, interview and review of the records. The findings are:	E 006	The All Hazards/Disaster Plan will be reviewed for each person at the Belmont Home to assure facility based and community based risk assessments, utilizing an all hazards approach including missing residents. Specifically, the 3 day, shelter in place disaster food menu and supplies will be replenished to reflect adequate amounts of both food and water for 7 persons for a 3 day shelter in place disaster. Also, individual disaster ID forms will be stored with the menu items, the emergency back pack and in each emergency car pack. These cards will have picture id of persons served, diagnoses, medications, crisis plans, communication preferences, and personal comforting items. Finally, the All Hazard plan will include how these ID forms will be on the person during evacuations, as well as, determining validation of community volunteers. The Belmont All Hazard plan will be reviewed at least annually by the QIDP and the All Emergency Committee for timely and recommended updates. It is the QIDP's responsibility to assure all ID info cards are current and available. It is the House Manager's responsibility to assure all supplies are correct and in date.	7/30/18

DHSR NHL & C Black Mountain WRO
Received
JUN 20 2018
by: SKH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda J. Stillwell — TITLE: Assistant Director — (X6) DATE: 6/19/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 006	Continued From page 1 Review of the facility's Emergency Plan (EP), conducted on 5/30/18, revealed the EP to contain a risk assessment and community based strategies. Continued review of the EP and interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed some additional facility based information needed to be developed to address the specific needs of the clients in the group home. For example: A. Review of the EP, substantiated by interview with QIDP, revealed one of the highest needs during emergencies is providing clients with food and supplies during inclement weather conditions. Continued review of the EP, verified by interview with the QP, revealed the amount of water required in the program plan would be 1 gallon of water per person for 5 clients and 3 staff, for a period of 72 hours, along with adequate food supplies for the same period of time. Observations in the home, substantiated by interview with the QIDP revealed only four 12 ounce bottles of water were available in the group home and two small plastic storage bins of food which would not be adequate to meet the full needs of clients and the requirements of the EP. B. Review of the EP revealed information regarding the residents of the group home was limited to the general information included on an informational face sheet. Interview with the facility QIDP revealed the facility was working on compiling more comprehensive client specific information and supplies to assist anyone unfamiliar with the clients in working with them in an emergency, however, this information was not currently available.	E 006		
W 323	PHYSICIAN SERVICES	W 323		7/30/18

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W 323	Continued From page 2 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 verified by interview, the facility failed to obtain an annual follow-up eye and an annual hearing exam as recommended by the physician for 1 of 3 sampled clients (#4). The finding is: Review of client #4's record on 5/30/18 revealed an annual eye exam dated 5/26/16 which documented prognosis of "progressive cataracts." The physician's recommendation from this eye exam was to "return in one year for a complete eye exam." Continued review of client #4's record revealed a hearing screening conducted on 3/2/16 with a physician's recommendation "to return in one year for full exam." Interview with the Qualified Intellectual Disabilities Professional and the facility nurse confirmed that the physician's recommendations for both exams have not been followed up, and are not scheduled to date for client #4. Therefore, the facility did not provide timely follow-up on the specialists' expressed recommendations.	W 323	Immediately, all five records will be re-viewed to ensure each person has an annual examination that at a minimum includes an evaluation of vision and hearing. Specifically, the follow up exams will be located or completed for person #4. Each other person's record will be reviewed to assure all CFAs are complete for any reccomendations made from the annual physical examinations that at a minimum includes an evaluation of vision and hearing. This will be reviewed by the QIDP and the Director of Nursing. It is the QIDP's responsibility to assure all test results are current and up to date and that all appts as recommended by any part of the CFA is also current and up to date and filed in the medical records.	7/30/18
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 3 This STANDARD is not met as evidenced by: The facility failed to assure fire evacuation drills were conducted at least quarterly for the 2nd shift of personnel and at varied times for the 3rd shift of personnel as evidenced by observation, interview and record verification. The findings are: A. Fire evacuation drills were not conducted quarterly for the 2nd shift of personnel during the annual review period. Review of the facility's fire evacuation drills for the past year revealed 2nd shift fire drills were conducted in the group home on 8/8/17, 12/16/17, and 5/28/18 during the annual review period. A second shift drill was not conducted between 12/16/17 and 5/28/18 a period of 5 months. Therefore, fire evacuation drills for the 2nd shift of personnel were not conducted at least quarterly as required. B. Fire evacuations drills were not conducted during varying times for the 3rd shift of personnel during the annual review period. Review of the facility's fire evacuation drills on 5/30/18 revealed 3rd shift fire drills were conducted at 11:00 PM on 6/7/17, at 11:15 PM on 9/10/17, at 12:00 AM on 11/7/17 and at 11:20 PM on 2/11/18. Further interview with the facility Qualified Intellectual Disabilities Professional (QIDP) confirmed the home's third shift fire drills were all conducted within the hour of 11:00 PM -12:00 AM for the annual review period. Continued interview with the QIDP revealed several clients are still awake and have not fallen asleep for the night during the hour of 11:00PM-12:00 AM.	W 440	The IDT for the Belmont ICF home will assure fire evacuation drills are conducted at least quarterly for all shifts and at varied times for the awake shift. The QIDP and House Manager will review the current system and determine the most likely cause of failure to include an afternoon evening evacuation drill. Additionally, the system will be updated to included varied conditions, such as a drill between 1am and 5am. This will be quality assured by the Assistant Director/ICF and reported to the GRSafety Committee for review. It is the responsibility of the House Manager to assure the fire evacuation, disaster evacuation, and disaster shelter in place drills, are conducted according to the GRSafety prescribed monthly drill (both fire and disaster) and properly documented to reflect compliance to this regulation.	7/30/18

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W 440	Continued From page 4 Subsequent interview with the QIDP revealed that staff and administration have been hesitant to conduct third shift fire drills beyond 12:00 AM with only one staff member present, because of the medical fragility of some of the clients within the home. However, the facility failed to hold 3rd shift drills under varied conditions to assure 3rd shift staff could evacuate the clients appropriately during a fire emergency.	W 440		