PRINTED: 07/10/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G142	B. WING	B. WING		07/	03/2018
	ROVIDER OR SUPPLIER	F/MR)		102 Q	T ADDRESS, CITY, STATE, ZIP CODE UAIL ROOST DRIVE RBORO, NC 27510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 006	CFR(s): 483.475(a)(1  [(a) Emergency Plan. and maintain an emer that must be reviewed annually. The plan must be assessment, utilizing to assessment, utilizing to assessment, utilizing to an and include a docu community-based risk all-hazards approach, to an anound the analysis of the approach, to a series of the assessment to the analysis of the assessment to the analysis of the analysis of the assessment to the analysis of t	The [facility] must develop regency preparedness plant, and updated at least ust do the following:]  Include a documented, inmunity-based risk an all-hazards approach.*  §483.73(a)(1):] (1) Be based umented, facility-based and cassessment, utilizing an including missing residents.  8.475(a)(1):] (1) Be based on ented, facility-based and cassessment, utilizing an including missing clients.  6 for addressing emergency in risk assessment.  18.113(a)(2):] (2) Include sing emergency events assessment, including the onsequences of power ters, and other emergencies nospice's ability to provide that as evidenced by: ew and interview, the facility mergency preparedness e geographic location of the reds of the facility in the zing an all-hazards	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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		34G142	B. WING			07/	03/2018
	OST GROUP HOME, (IC	F/MR)	STREET ADDRESS, CITY, STATE, ZIP CODE  102 QUAIL ROOST DRIVE  CARRBORO, NC 27510		02 QUAIL ROOST DRIVE		
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E 006	Review on 7/2/18 of trevealed the plan did information in regards of the facility and the in the risk assessment approach.  Interview on 7/2/18 w disabilities profession not aware of this and this issue with the EP Development of EP P CFR(s): 483.475(b)  (b) Policies and procedur plan set forth in paragasessment at paragand the communication this section. The policies and updated *Additional Requirem Facilities:  *[For PACE at §460.8] procedures. The PAC develop and implement policies and procedures and procedure plan set forth in paragassessment at pa	ve an emergency plan sements.  the facility's current EP plan not provide specific to the geographic location clients' needs of the facility at, utilizing an all-hazards  ith the qualified intellectual al (QIDP) revealed she was would be working to correct plan.  olicies and Procedures  edures. [Facilities] must not emergency preparedness es, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be diat least annually.  eents for PACE and ESRD		006			
		ies and procedures must t of medical and nonmedical					

NAME OF PROVIDER OR SUPPLIER  QUAIL ROOST GROUP HOME, (ICP/MR)    CARBORO, NC 27510   CROME PRICE CONTROL OF CORRECTION SHOULD BE CHARGE CHARG		EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING		(X3) DATE SURVEY COMPLETED				
SUMMARY STATEMENT OF DEFICIENCIES   PREPRICE   PROPROSES PLAND F CORRECTION   PREPRIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG			34G142	B. WING			07/0	3/2018
IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)    E 013   Continued From page 2   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 \$494.82(b):] Policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a) 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:			F/MR)		102 QUAIL ROOST DRIVE			
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 (o) 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:	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	E	COMPLETION
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 032 Primary/Alternate Means for Communication E 032 CFR(s): 483.475(c)(3)		emergencies, includir equipment, power, or emergencies; and na threaten the health or staff, or the public. The must be reviewed and *[For ESRD Facilities procedures. The dialy implement emergence procedures, based or forth in paragraph (a) assessment at paragrand the communication this section. The policities reviewed and updated emergencies include, equipment or power from the emergencies, water is natural disasters likely geographic area. This STANDARD is represent and their case of an emergency prepared assessment and their case of an emergency the facility. The findir During an interview or revealed they did not procedures specifical preparedness plan. How or king to develop the procedures. Primary/Alternate Me	ng, but not limited to: Fire; water failure; care-related tural disasters likely to a safety of the participants, he policies and procedures disasted updated at least annually.  at §494.62(b):] Policies and visis facility must develop and by preparedness policies and in the emergency plan set of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be did at least annually. These but are not limited to, fire, adilures, care-related supply interruption, and by to occur in the facility's anot met as evidenced by: the facility failed to develop procedures to address hess, considering risk recommunication plan in the policies and ly for the emergency lowever, they have been ese policies and ans for Communication					

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E 032	[(c) The [facility] must emergency prepared that complies with Fe and must be reviewed annually.] The communicating with the emergency managem.  *[For ICF/IIDs at §483 alternate means for communicating with the emergency managem.  *[For ICF/IIDs at §483 alternate means for communicating with facility failed to develor communicating with failed to develor communication with failed to develor communicati	develop and maintain an mess communication plan deral, State and local laws d and updated at least unication plan must include mate means for the following:  al, regional, and local ment agencies.  3.475(c):] (3) Primary and communicating with the al, State, tribal, regional, and agement agencies. The met as evidenced by: ation and interviews, the cop an alternate means for acility staff, regional and ring an emergency. The evelop an alternate means th staff, regional and local an emergency.  The facility's emergency d not include any alternate means of met 7/3/18, management me phone and cell service not aware of another way to	E	032				
E 037		an omorgonoy.	E	)37				

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E 037	ASCs, PACE organiza and dialysis facilities]  (i) Initial training in en policies and procedur staff, individuals proviarrangement, and vol expected role.  (ii) Provide emergence least annually.  (iii) Maintain documer (iv) Demonstrate staff procedures.  *[For Hospitals at §48 at §491.12:] (1) Trainior RHC/FQHC] must (i) Initial training in en policies and procedur staff, individuals proviarrangement, and vol expected roles.  (ii) Provide emergence least annually.  (iii) Maintain documer (iv) Demonstrate staff procedures.  *[For Hospices at §41 hospice must do all of (i) Initial training in en policies and procedur hospice employees, a services under arrange expected roles.	The [facility, except CAHs, ations, PRTFs, Hospices, must do all of the following: nergency preparedness tes to all new and existing iding services under unteers, consistent with their try preparedness training at thation of the training. It knowledge of emergency sees to all new and existing iding program. The [Hospital do all of the following: nergency preparedness tes to all new and existing iding on-site services under unteers, consistent with their try preparedness training at thation of the training. It knowledge of emergency	E	037			

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E 037	least annually.  (iv) Periodically revie emergency prepared employees (including special emphasis pla procedures necessa others.  *[For PRTFs at §441 program. The PRTF (i) Initial training in epolicies and procedustaff, individuals programs arrangement, and vocamed expected roles.  (ii) After initial training preparedness training (iii) Demonstrate starprocedures.  (iv) Maintain docume preparedness training in epolicies and procedures and procedustaff, individuals programs arrangement, contravolunteers, consister (ii) Provide emergen least annually.  (iii) Demonstrate starprocedures, including what to do, where to case of an emergence	ew and rehearse its liness plan with hospice g nonemployee staff), with liced on carrying out the ry to protect patients and  .184(d):] (1) Training must do all of the following: mergency preparedness res to all new and existing viding services under plunteers, consistent with their g, provide emergency g at least annually. If knowledge of emergency entation of all emergency g.  84(d):] (1) The PACE o all of the following: mergency preparedness res to all new and existing viding on-site services under ctors, participants, and out with their expected roles. cy preparedness training at  ff knowledge of emergency g informing participants of go, and whom to contact in	E	037			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION  G		
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E 037	CORF must do all of (i) Provide initial train preparedness policical and existing staff, in under arrangement, with their expected (ii) Provide emerger least annually. (iii) Maintain docum (iv) Demonstrate staprocedures. All new and assigned specific the CORF's emergentheir first workday. Their first workday workday workday. Their first workday workday workday workday. Their first workday. Their first workday. Their first workday workday workday workday workday workday workday workday workday. Their first workday wo	is 5.68(d):](1) Training. The fithe following: ning in emergency es and procedures to all new adividuals providing services and volunteers, consistent roles. Incy preparedness training at entation of the training. If knowledge of emergency apersonnel must be oriented fic responsibilities regarding ency plan within 2 weeks of the training program must in the location and use of signals and firefighting.	E 03	37		
	(ii) Provide emerger least annually. (iii) Maintain docum	ncy preparedness training at entation of the training.  aff knowledge of emergency				

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E 037	CMHC must provide in preparedness policies and existing staff, ind under arrangement, as with their expected rodocumentation of the demonstrate staff knot procedures. Thereafte emergency prepared annually.  This STANDARD is in Based on interview a failed to assure direct trained on the facility's finding is:  Staff had not received emergency plan (EP)  Review on 7/2/18, of training inservice she regards to fire and distributions of the staff county of the staff	in 1920(d):] (1) Training. The nitial training in emergency is and procedures to all new initials providing services and volunteers, consistent les, and maintain training. The CMHC must eviledge of emergency er, the CMHC must provide mess training at least and record review, the facility care staff were sufficiently is emergency plan (EP). The diadequate training on the effective for direct care staff in easter drills.  In 7/2/18 revealed the libel to provide the fire drills and disaster drills; ald not provide specific training they received for	E	037			
W 383	to the facility's EP. DRUG STORAGE AN CFR(s): 483.460(I)(2)	ID RECORDKEEPING	w:	383			

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W 383	This STANDARD is represented to assure only a access to the keys to potentially affected all finding is:  The key to the medical assessable.  During morning medical home on 7/3/18, at appreciation techniciar to assist a client with Further observations keys were left on the surveyor was left alor where the closet is lominutes.  Additional observation in the home on 7/3/18 the medication technic room to assist a client keys on the table unalleft alone in the medical approximately 2, minuted.	ons may have access to the age area.  not met as evidenced by: ns and interviews, the facility authorized persons have the medication closet. This I clients in the home. The  ation closet was left  cation administration in the proximately 7:10am, the exited the medication room their morning routine. revealed the medication table unattended. The ein the medication room, cated, for approximately 4,  ns medication administration 8, at approximately 7:40am, cian exited the medication tand left the medication tand left the medication ittended. The surveyor was cation room, for utes.	W	383			
		er interview revealed all					

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