DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/1/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(O(2) Mich	TIPLE CONSTRUCTION	OMB NO. 0938-0
IDENTIFIC		IDENTIFICATION NUMBER:	A BUNDING		(X3) DATE SURVEY COMPLETED
		34G306; .			
vame of Pi Brookw	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 21P COD 313 EAST BROOKWOOD AVENUE	06/06/2018 E
				LIBERTY, NG 27298	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	01		
PREFIX TAG	CAUT DEFICIENC	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	PREFI		I CHOLD DOD
E 037	EP Training Program CFR(s): 483.475(d)(1)	· :	E	037	8-5-19
	ASUS PAUL Organiza	The [facility, except CAHs, ations, PRTFs; Hospices, must do all of the following;			
			ř	E 037 1	
Ì	porces and procedure	ergency preparedness as to all hew and existing	ŀ		
	Stair, individuals provid	DING Services under	}	The OP will schedule tra	
	ехрескео гона.	Unteers, consistent with their		the emergency plan for	*all direct
	<ul><li>(ii) Provide emergency least annually.</li></ul>	r preparedness training at		care staff, including the manager.	home
1	(lii) Maintain documen	tation of the training.	Ì	11101(0Ee)	
1	(iv) Demonstrate staff procedures.	knowledge of smergericy	<u> </u>	The QP will ensure train	
·	*[For Hospitals at \$482	2.15(d) and RHCs/FQHCs	ľ	Emergency Plan for all 1	
]	or RHC/FQHCI must d	ig program. The [Hospital		and conduct annual tra .staff.;	ining on all
1 1	policies and procedure	ergency preparedness s to all new and existing		The QP will monitor eve	erv:6
,	stair, individuals provid	ling on-site services under nteers, consistent with their		months to ensure comp	, , ,
	(ii) Provide emergency east annually.	preparednèss fraining at		RECEIVED	
) (	iii) Maintain document iv) Demonstrate staff i	allon of the training. (nowledge of emergency		i	
*	procedures.			JUL C 2 2013	
	[For Hospices at §418 nospice must do all of p l) Initial training in eme	.113(d):) (1) Training. The the following:		DHSR-MH Licensure	Sect
F	oncies and procedure: lospice employees, an	s to all new and existing			
9	ervices under arrange expected roles.	ment, consistent with their	*		
- P	roceaures.	nowledge of emergency			
CATORY-DIE	ECTORS OR PROVIDER/SUI	PPLIER REPRESENTATIVES SIGNATURE	1	A Title 2	
	Moreon ending with an auto			Qualified Prop	lesonal (0/2)

Any deficiency statement ending with an autients, (\*) denotes a deficiency which the institution may be excused them correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings related above are disclosed by 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 disclosed by 14 days following the date these documents are made available to the facility. If deficiences are clad, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Ventions Obscieto

Event 10: 15XR11:

Facility ID: 924983

If continuation sheet Page 1 or 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: ,06/11/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES QMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA. (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A BUILDING 34G306 B. WNO NAME OF PROVIDER OR SUPPLIER. 06/06/2018 STREET ADDRESS, CITY, STATE, ZIP CODE BROOKWOOD 313 EAST BROCKWOOD AVENUE LIBERTY, NC 27298 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES: PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION CATE PREFIX. (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY). E 037 | Continued From page 1 E 037 (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, TFor PRTFs at §441.184(d):] (1). Training program. The PRTF must do all of the following: (i) Initial training in emergency preparadness 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. FORM CMS-2587(02-99) Previous Versions Obsoloté Even! 10: 53(R11 Facility ID: 924983 If continuation sheet Page 2·0/8

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 06/11/2018 FORM APPROVED

STATEMENT OF CORRECTION (X1). PROVIDENT		(X1). PROVIDER/SUPPLIER/CUA	ON MULTIPLE CO	ONIGOTORIA	OMB NO. 0938-039
		IDENTIFICATION NUMBER:	DERAUPPÜERICUA FICATION NUMBER:  A BUILDING		(X3) DATE SURVEY COMPLETED
		34G305	B.WING	<u> </u>	
NAME OF PROVIDER OR SUPPLIER.			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	06/06/20/18
BROOKW			213 (	EAST BROOKWOOD AVENUE ERTY, NO. 27298	
(X4) (D PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	, all	PROVIDERS PLAN OF GOR	
TAG			PREFIX: TAG	(EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	SECULATION CONT.
€ 037°	Continued From page	.9			
		68(d):](1)  Training. The	E 037	:	
	CORF must do all of t	be following. The	į.	•	
	(i) Provide initial trainil	70 in emergebou		•	
	preparedness policies	and procedures to all new			The same of the sa
	and exasting staff, Indi-	viduals providing services			
	under arrangement ar	nd voluntéers, consistent	1		
	with their expected role	89:			
	least annually.	preparedness training at		:	
	(iii) Maintain document	fation of the familian	1		
	(iv) Demonstrate staff	knowledge of emergency			
	procedures. All new pe	PISORDAL must be opened		•	
į	and assigned specific i	responsibilities requesting		•	
}	the CORF's emergence	V blan within 2 weeks of			
	their hist workday. The	training brogram must		:	
į	include instruction in the	e location and use of	}		
	alarm systems and sign equipment.	nais and tiretighting			
	*[For CAHs at §485,62	5(d):] (1) Training program.		•	
}	THE CALL MUST GO SILO	r the following:	}	•	
	(i) Initial training in eme	orgency preparedness	<b>!</b>		
	policies and procedure	s, including prompt			
	and where necessary,	hing of fires, protection,		•	
	personnel, and guests,	first provide the patients,		;	
1	cooperation with firefigi	Othic and disaster		·	
	authorities, to all new a	nd existing staff		•	
I	individuals providing se	TVICES undergrangement			
1	and volunteers, consist	ent with their expected			a de la companya de l
	roles.	:		!	
	(ii) . Provide emergency	preparedness training at		,	
	least annually. (iii) Maintain documenta	ation of this testate		;	
	(iv) Demonstrate staff in	nowledge of emergency			
,	procedures.				
1.	TEOT CMHC - 145495 0	30(4)(4)(Table	i	•	
į	f1 -1111102 at 2402'8'	20(d):] (1) Training. The		i	
RM CMS Servin	02-99) Provious Versions Obsolei		1		
· ··· · · · · · · · · · · · · · · · ·	nc-aal Lieubina neuslous Opzolei	te .Eveni (D:/5XR*)	T Facility (D	( . 924983.	If Crinting prior characters in a co

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/11/2018 CENTERS FOR MEDICARE & MEDICARD SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING. COMPLETED 34G308 B. WING NAME OF PROVIDER OR SUPPLIER 06/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE BROOKWOOD 313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298 SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLANOF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION DATE PREFIX TAG TAR DEFICIENCY E 037 Continued From page 3 E 037 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 facilityfailed to ensure direct care staff were sufficiently trained on the facility's emergency plan (EP). The finding is:. Staff had not received training on the EP. Review on 6/5/16 of the facility's documentation revealed no documented specific training for direct care staff in regards to the EP. Staff interview (1) on 8/5/18 revealed they have been trained regarding fire drills and disaster drills; however, the staff were not trained on the facility's EP program. Staff interview (1) on 6/6/18 revealed they have been trained regarding fire drills disaster drills and trained on the facility's EP.

FORM CM9-2567(02-99) Previous Versions Obsolete.

CFR(s): 483.420(a)(3)

W 125

Interview on 6/5/18 with the qualified intellectual disabilities professional (QIDP) confirmed direct care staff have not received any training concerning the EP because it was new.

PROTECTION OF CLIENTS RIGHTS

Event ID: ISXR11

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W 125

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/11/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERICULA IDENTIFICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION OX2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 34G305 B. WING NAME OF PROVIDER OR SUPPLIER 06/08/2018 STREET, ADDRESS; CITY, STATE, ZIP GODE BROOKWOOD 313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298 (X4)·ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX: TAG' REGULATORY OR LSC IDENTIFYING INFORMATION) (PXG) W 125 Continued From page 4 18-5-18 W 125 The facility must ensure the rights of all clients: Therefore, the facility must allow and encourage individual clients to exercise their rights as clients W 125 of the facility, and as citizens of the United States, including the right to file complaints, and the right The facility will advocate and to due process. promote the protection of client This STANDARD is not met as evidenced by: Based on record review and interview, the facility right to include due process such failed to ensure client#2 had a legal guardian. as guardianship. This affected 1 of 3 audit clients. The finding is: For Client 2#, The QP will Client#2 has no documentation of a legal coordinate with family, DSS, Clerk guardian, or Court and file paperwork for Review on 6/6/18 of client #2's record revealed guardianship. The Petition will be no documentation to confirm she has a legal file with the clerk of Court. QP will guardian. document the status in client's Interview on 6/6/18 with qualified intellectual record. disabilities professional (QIDP) confirmed client #2's record has no documentation to confirm she has a legal guardian; however, the QIDP confirmed she would work expediently to obtain the documentation. W 164 PROFESSIONAL PROGRAM SERVICES W 184 CFR(s): 483.430(b)(1) Each client must receive the professional program services needed to Implement the active treatment program defined by each client's individual program plan.

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

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility
failed to ensure individuals receive professional
services when the active treatment program

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If continuation shoot Page: 5 of 8

CENTE	YS FOR MEDICARE &	ND. HUMAN SERVICES MEDICAID SERVICES			FORM	: 06/11/201 APPROVE
OND DIANTOR COMMERCE.		(X1) PROVIDERSUPFLIERICIA IDENTIFICATION NUMBER:	OS) MULTIPLE CONSTRUCTION.			0938-039 NEVEY ETED
		34G305	B. WING.			
BROOKW	700D		31	REET ADDRESS, CITY, STATE, ZIP CODE, IS EAST BROOKWOOD AVENUE BERTY, NC 27298	1 06/0	6/2018
(X4) ID PREFIX TAG	I LEACH DEFICIENCY	atement of deficiencies Karustibe preceded by Full Scidentifying information;	ID: ;PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPE DEFICIENCY)	DC I	(X6) COMPLETION DATE
	defined by the individual requires the knowledge someone specially transmission. This affected 1 of 3 at lat.  The facility has not has since her admission.  Review on 6/6/18 of clareview dated 4/24/18 in notes indicating she is health provider and he "Adjustment Disorder-F43:23."  Review on 6/6/18 of clareview of client #4's cut individual program plans revealed no recent psychological program plans individual program plans revealed no recent psychological psycholo	ual program plan (IPP)  ie, skills and expertise of ired in a given discipline; adit clients (#4). The finding of a psychiatrist for client #4  ient #4's quarterly drug evealed the pharmacists in need of a "behavior of diagnosis includes Mixed Emotional Features ent #4's recent quarterly dated 5/3/18 and 2/27/18 "Need for of ir seeking behavior of ir seeking behavior ent #4's current records poort plan (BSP) dated for and Abilify. Additional ment records including her (IPP) dated, 9/1/17 chiatric notes or visits.  If the nurse confirmed a psychiatrist since her if the qualified lintellectual (QIDP) reveeled client #4. by a nearon properties of the proposition of the properties of the psychiatrist since her if the qualified lintellectual (QIDP) reveeled client #4.	W 164	W 164  The facility will ensure services provided to individuals as identified in the individual propian.  For Client #4 a psychiatrist visit be schedule by the QP. The QF document the schedule visit in Client's record. Documentatio the psychiatrist assessment will secure for the record.  QA will monitor quarterly in the records for compliance.	are gram will will the n of	5-5-18

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FAX No. 3363701023

Event ID: EXRIT

Facility ID: 924983

If cointinuation sheet Page 6 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2018 FORM APPROVED

AND PLAN OF CORRECTION (DENTIFICATION NUMBER:  34G305  NAME OF PROVIDER OR SUPPLIER		(DENTIFICATION NUMBER:	A BUILDING	COMPLE		URVEY	
		B.:WING		10 <i>6/</i> 2	/2018		
BROOKW			] :	STREET ADDRESS, CITY, STATE, ZIP CODE 313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298			
(X4) (D PREFIX TAG	IEACH DENICIEN	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	ID' PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	700	¢c	(X5) MPLETI DATE
W 285	has not seen a psych on 7/28/15 and was.i	edications listed on her BSP. confirmed on 6/6/18 client #4 slattist since her admission on need of a psychiatrist to on BSP psychotherapeutic	W 164		8	5-	18
	Interventions to mana behavior must be em saféguards and suce	ga inappropriate client ployed with sufficient: Mision to ensure that the		W 285  The facility will ensure approsupervision such that clients individual and civil rights are protected.	İ		
i 3 4 8 8 8 8 9 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	pased on observation interview, the facility for manage inappropriation manage inappropriation amployed with sufficient upervision to ensure the supervision to ensure the supervision to ensure the finding and human rights protected. The finding allient #2 directed other supervision of the finding allient #2 directed other supervisions.	ailed to ensure interventions ate client (#2) behavior be nt safeguards and that the safety, welfare and of clients are adequately is:		The QP will in service staff or #2's Behavior Support Plan (I Client #2 will be redirected for such behavior of telling peer take medications.  The Home Manager and for monitor in the home during permanents.	SSP).  Form  S do so  QP will		
to te	Disservations on 6/6/4: noming medication ac istructing clients seat by go take their medical echnician requested e m on 6/6/18, staff told tedications. Then clie	medications.  8 in the home during iministration revealed staff and in the home's living area tions as the medication ach. At approximately 8:05 I client #5 to go take her not #2 said, "Client #5 go attons" and "Client #5 go		Pass monthly to ensure.	ingu.		

P. 009

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/11/2018. FORM APPROVED

STATEMENT OF DEFICIENCIES	(X4) PROMOTER VIGES	<del></del>		OMB NO	0 003	STUSON
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	(X3) DATE		·	
34G305		a. Wikid	ļ			
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298	. 06/1	06/20	18
PREFIX (EACH DEFI	RY STATEMENT OF DERICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR USCHDENTIFYING INFORMATION)	ID PREFIX TAG.	PROVIDERS PLAN OF CORP (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	Uninner !	COMP	(S) LETION ATE
approximately 8: instructing anoth medications after client #i to go tall approximately 8: go take her medications. At in redirecting client take their medications, At in redirecting client take their medical interview on 8/6/1 just loves to talk* clients what to do any mind." In add is not addressed plan (BSP).  Review on 6/6/18 plan (IPP) dated 3/417/16 for the client their medication/misus Aggression/Inapp yelling, threats, ne "Noncompliance/f Behavior (SIB)"  Interview on 6/6/1 disabilities profess time should client, their medications, anything. Further,	ions on 6/6/18 in the home nedication administration at. 15am revealed client #2 er peer (client #1) to go take her retaff had already instructing ke her medications. Then, at 25am, staff instructed client #6 to cations and client #2 again was cting client #6 to go take her to time was staff observed #2's behavior of telling clients to tions.  18 with staff revealed "client #2 and "she tries to tell" other and "she tries to tell" other in client #2's behavior support.  16 client #2's behavior support.  17 of client #2's individual program and "she tries are alled this behavior in client #2's behavior support.  18 of client #2's individual program and "she tries in alled a BSP dated and "Verbal propriate in and "Verbal propriate it in decrease in appropriate in an are calling" and "Self Injurious are calling" and "Self Injurious B with the qualified intellectual solonal (QIDP) confirmed at no #2 instruct clients to do it instruct clien	W 28				

FURM CMS-2967(02-99) Previous Versions Obsolete

Event ID; ISXR11

Facility (D) 92/468/3.

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