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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G305	A. BUILDING _____ B. WING _____	06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298

(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 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. (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.	E 037	E 037 1 The QP will schedule training on the emergency plan for all direct care staff, including the home manager. The QP will ensure training on the Emergency Plan for all new staff and conduct annual training on all staff. The QP will monitor every 6 months to ensure compliance. RECEIVED JUL 0 2 2018 DHSR-MH Licensure Sect	8-5-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lorianne Jarrell | TITLE: Qualified Professional | (X6) DATE: 6/21/18

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 037	Continued From page 1 (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 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.	E 037		

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E 037	Continued From page 2 *[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 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	E 037		

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	34G306	A. BUILDING _____ B. WING _____	06/06/2018

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E 037	Continued From page 3 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 failed 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 6/5/18 of the facility's documentation revealed no documented specific training for direct care staff in regards to the EP. Staff interview (1) on 6/5/18 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. 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.	E 037		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)	W 125		

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	346305	A. BUILDING _____ B. WING _____	06/08/2018

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W 125	Continued From page 4 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 record review and interview, the facility failed to ensure client #2 had a legal guardian. This affected 1 of 3 audit clients. The finding is: Client #2 has no documentation of a legal guardian. Review on 6/6/18 of client #2's record revealed no documentation to confirm she has a legal guardian. Interview on 6/6/18 with qualified intellectual 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 125	W 125 The facility will advocate and promote the protection of client right to include due process such as guardianship. For Client 2#, The QP will coordinate with family, DSS, Clerk or Court and file paperwork for guardianship. The Petition will be file with the clerk of Court. QP will document the status in client's record.	8-5-18
W 164	PROFESSIONAL PROGRAM SERVICES 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. 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	W 164		

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W 164	Continued From page 5 defined by the individual program plan (IPP) requires the knowledge, skills and expertise of someone specially trained in a given discipline. This affected 1 of 3 audit clients (#4). The finding is: The facility has not had a psychiatrist for client #4 since her admission. Review on 6/6/18 of client #4's quarterly drug review dated 4/24/18 revealed the pharmacist's notes indicating she is in need of a "behavior health provider" and her diagnosis includes "Adjustment Disorder - Mixed Emotional Features F43.23." Review on 6/6/18 of client #4's recent quarterly nursing assessments dated 5/3/18 and 2/27/18 revealed the following: "Need for psych. Evaluation. plan for seeking behavior health provider." Review on 6/6/18 of client #4's current records revealed a behavior support plan (BSP) dated 8/31/17 of which incorporates restrictive techniques and the use of psychotherapeutic medications - Klonopin and Abilify. Additional review of client #4's current records including her individual program plan (IPP) dated 9/1/17 revealed no recent psychiatric notes or visits. Interview on 6/6/18 with the nurse confirmed client #4 has not seen a psychiatrist since her admission. Interview on 6/6/18 with the qualified intellectual disabilities professional (QIDP) revealed client #4 is consistently followed by a neurologist for seizure management of which Abilify is one of the	W 164	W 164 The facility will ensure services are provided to individuals as identified in the individual program plan. For Client #4 a psychiatrist visit will be schedule by the QP. The QP will document the schedule visit in the Client's record. Documentation of the psychiatrist assessment will be secured for the record. QA will monitor quarterly in the records for compliance.	8-5-18

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W 164	Continued From page 6 psychotherapeutic medications listed on her BSP. However, the QIDP confirmed on 6/6/18 client #4 has not seen a psychiatrist since her admission on 7/28/15 and was in need of a psychiatrist to follow her progress on BSP psychotherapeutic medications.	W 164		
W 285	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure interventions to manage inappropriate client (#2) behavior be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. The finding is: Client #2 directed other clients residing in the home to go take their medications. Observations on 6/6/18 in the home during morning medication administration revealed staff instructing clients seated in the home's living area to go take their medications as the medication technician requested each. At approximately 8:05 am on 6/6/18, staff told client #5 to go take her medications. Then client #2 said, "Client #5 go take your biotics medications" and "Client #5 go take your antibiotics medications."	W 285	8-5-18 W 285 The facility will ensure appropriate supervision such that clients individual and civil rights are protected. The QP will in service staff on client #2's Behavior Support Plan (BSP). Client #2 will be redirected from such behavior of telling peers do so take medications. The Home Manager and /or QP will monitor in the home during med. Pass monthly to ensure.	

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W 285	Continued From page 7 Further observations on 6/6/18 in the home during morning medication administration at approximately 8:15am revealed client #2 instructing another peer (client #1) to go take her medications after staff had already instructing client #1 to go take her medications. Then, at approximately 8:25am, staff instructed client #6 to go take her medications and client #2 again was heard also instructing client #6 to go take her medications. At no time was staff observed redirecting client #2's behavior of telling clients to take their medications. Interview on 6/6/18 with staff revealed "client #2 just loves to talk" and "she tries to tell" other clients what to do; however, clients "don't pay her any mind." In addition, staff revealed this behavior is not addressed in client #2's behavior support plan (BSP). Review on 6/6/18 of client #2's individual program plan (IPP) dated 3/30/18 revealed a BSP dated 4/17/18 for the client to decrease inappropriate behaviors including "Property destruction/misuse..." and "Verbal Aggression/Inappropriate Language...cursing, yelling, threats, name calling..." and "Noncompliance/Resistance..." and "Self Injurious Behavior (SIB)..." Interview on 6/6/18 with the qualified intellectual disabilities professional (QIDP) confirmed at no time should client #2 instruct other clients to take their medications or instruct clients to do anything. Further, the QIDP confirmed client #2's BSP is in need of addressing her behaviors of telling clients what to do.	W 285		