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NORTHSIDE GROUP HOME	3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301

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E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(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 7/10/18 of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication. During an interview on 7/10/18, qualified intellectual disabilities professional (QIDP) revealed if the land line phone and cell service were down they were not aware of another way to	E 032		

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

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E 032	Continued From page 1 communicate during an emergency, with the exception of driving to communicate any needed information.	E 032		
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	E 036		

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E 036	Continued From page 2 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing 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 7/10/18 of the facility's EP manual, it did not include any information on training or testing for the staff. During interviews on 7/9/18 and 7/10/18, staff revealed they had not been received any training and testing on the emergency preparedness plan and they have only conducted the basic drills. During an interview on 7/10/18, the qualified intellectual disabilities professional (QIDP) confirmed they had no documentation for staff training or testing regarding the emergency preparedness plans. He further stated this is something they are still working on.	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	E 037		

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E 037	Continued From page 3	E 037		

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.
(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

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E 037	Continued From page 4 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. *[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.	E 037		

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E 037	Continued From page 5 (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 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	E 037		

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E 037	Continued From page 6 procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interviews and document review, the facility failed to assure direct care staff were sufficiently trained on the facility's emergency preparedness plan (EP). The finding is: Staff had not received adequate training on the facility's emergency preparedness plan (EP). Review on 7/10/18 of facility documents did not reveal any training inservice sheets for staff in regards to emergency preparedness disaster drills. During interview on 7/10/18, staff revealed they only complete the regular assigned drills. The staff were not able to specify the emergency preparedness training they had received from the facility. During an interview on 7/10/18, the qualified intellectual disabilities professional (QIDP) revealed he did not conduct or have any information on staff receiving any training specific to the facility's emergency preparedness plan. He further stated they are still working on the plans and training.	E 037		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted	W 210		

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W 210	Continued From page 7 prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to assure the interdisciplinary team performed accurate assessment(s) within 30 days after admission. This affected 1 of 3 audit client (#3). The finding is: Client #3 was not accurately assessed by the interdisciplinary team in a timely manner. Review on 7/9/18 of client #3's record revealed he was admitted into the facility on 7/25/17. Further review of client #3's record revealed an occupational therapy and speech language evaluation dated 9/25/17. These assessments were not completed within 30 days after client #3's admission into the facility. During an interview on 7/9/18, the qualified intellectual disabilities professional (QIDP) confirmed the assessments were not completed within 30 days of client #3's admission.	W 210		
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.	W 249		

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This STANDARD is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to assure each client received a continuous active treatment plan consisting of needed interventions and services as identified in their individual program plan (IPP) in the area of knife availability/usage and program implementation during toothbrushing. This affected 1 of 3 audit clients (#2). The findings are:

1. Client #2 was not afforded a knife and the opportunity to consistently cut her meat.

During observations of the dinner meal in the home on 7/9/18, a staff sat on client #2's right side, looked on as client #2 held her whole thick pork chop in her hands as she took bites from it. The meat appeared to be thick, tough and difficult for client #2 to bite and chew. Client #2 did not have a knife available at the table and a knife was not offered her. Staff did not prompt or offer assistance to client #2 with cutting her meat.

Review on 7/10/18 of client #2's individual program plan (IPP) 6/22/18 revealed, "[Client #2] will need staff assistance when utilizing a knife to cut meat or other thick foods."

During an interview on 7/10/18, the qualified intellectual disabilities professional (QIDP) confirmed a knife should have been available at the table for client #2's use. However, a knife should have been offered and staff should have assisted client #2 with cutting her meat.

2. Clients #2's toothbrushing objective and

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method were not implemented as written.

During observations in the home on 7/9/18 after dinner, client #2 went to the bathroom with staff in the doorway looking on as the client brushed her teeth. Client #1 was observed to use a battery operated manual toothbrush. Client #2 was verbally instructed on which surface areas of her teeth to brush. Client #2 brushed her teeth for approximately 1 and half minutes. There were no timing devices used while client #2 brushed her teeth. The staff wore disposable gloves; however, the staff did not physically help client #2 with brushing her teeth or encourage client #2 to brush her teeth longer and/or more thoroughly.

Review on 7/10/18 of client 2's individual program plan (IPP) dated 6/22/18 revealed an objective to brush her teeth, implemented 10/11/17.

Review on 7/10/18 of client #2's toothbrushing method revealed, "...STAFF WILL SET THE TIMER FOR 3 MINUTES. - STAFF WILL ENCOURAGE THE CONSUMER TO BRUSH AS THOROUGHLY AS POSSIBLE. - STAFF WILL HELP CONSUMER TO BRUSH HER TEETH THOROUGHLY EACH TRIAL...."

During an interview on 7/9/18, the staff revealed, "She could of done better, she gets a little fussy at times."

During an interview on 7/10/18, the qualified intellectual disabilities professional (QIDP) confirmed client #2's toothbrushing objective should have been implemented as written. Further interview confirmed they do not have any timers available for use in the home and they do not have clocks in the bathrooms to ensure the

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W 249	Continued From page 10 clients' are brushing for the amount of time indicated in their programs.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure a technique to manage client #3's behavior was included in a formal active treatment plan. This affected 1 of 3 audit clients. The finding is: The use of Atatrax, Zyprexa and Risperdal was not included in client #3's behavior intervention program (BIP). Review on 7/9/18 of client #3's BIP consent form dated 7/27/17 revealed an objective. The plan included the use of Seroquel and Depakote. Review on 7/9/18 of client #3's current physician's orders dated 7/1-31/31/18 identified orders for Atarax, Zyprexa and Risperdal for behaviors. Further review of the record did not reveal the use of Atarax, Zyprexa and Risperdal were incorporated into a BIP. Interview on 6/12/18, the qualified intellectual disabilities professional (QIDP) confirmed client #3 consumes Atarax prior to dental appointments and the medication should be included in his BIP.	W 288		
W 322	PHYSICIAN SERVICES	W 322		

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W 322	Continued From page 11 CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 1 female audit clients (#2) obtained a complete physical examination to included a pap smear and a mammogram. The finding is: Client #2 did not receive a complete physical examination nor a pap smear and mammogram. Review on 7/10/18 of client #2's record did not reveal any information for a current or past gynecology (GYN) evaluation nor a mammogram. Review of client #2's physical examination dated 6/19/18 revealed only vital signs and, ""Purpose of Visit...referral for a gynecological exam -mammogram-last date 5/9/17...Orders... > refusal to gyn > routine mammogram this year...." Further review did not reveal any information to indicate a GYN assessment nor a mammogram was completed. The qualified intellectual disabilities professional (QIDP) revealed client #2's mother believes in holistic medicine and did not want her to receive PAP smear nor mammogram. However, there was no information from the physician as to any medical reasons/concerns for client #2 not to have a PAP smear nor a mammogram. Also there were no current team meeting information to indicate the teams discussion/decision about the client #2 not to receive a GYN evaluation nor a mammogram.	W 322		

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W 322	Continued From page 12 During an interview on 7/10/18, the (QIDP) revealed client #2's mother believes in holistic medicine and did not want her to receive PAP smears nor mammogram. He also confirmed he was unaware the team had to meet to discuss and come to a decision about client #2 receiving a GYN evaluation and a mammogram. Additional interview confirmed client #2 should receive a complete physical to include a GYN assessment and a mammogram yearly and/or as ordered by the physician.	W 322		
W 323	PHYSICIAN SERVICES 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 interview the facility failed to assure each client received adequate annual physical examination which included a visual evaluation. This affected 1 of 3 audit clients (#2). The finding is: Client #2 did not receive an adequate annual physical to include a visual evaluation. Review on 7/10/18 of client #2's physical evaluation dated 6/19/18 did not reveal a complete 2018 physical evaluation, which included a visual assessment was completed. Client #2 wears prescription eye glasses. There was no information available for review in regards to any of her past or current optical assessments. During an interview on 7/10/18, the qualified	W 323		

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W 323	Continued From page 13 intellectual disabilities professional (QIDP) confirmed client #2's vision was not assessed during her annual physical. Also there was no past nor current information available for review on her optical assessment.	W 323		
W 350	DENTAL SERVICES CFR(s): 483.460(e)(3) The facility must provide education and training in the maintenance of oral health. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure training was provided for the maintenance of the clients' oral health. This affected 2 of 3 audit clients (#1 and #3). The findings are: 1. Training was not provided to address improving client #3's oral health. Review on 7/9/18 of client #3's dental report dated 3/27/18 revealed, "Oral hygiene- poor (heavy gingivitis)." Review on 7/9/18 of client #3's individual program plan (IPP) dated 8/23/17 revealed, "By 8/22/18 [Client #3] will brush his teeth 3X daily with 100% accuracy for 3 consecutive months." Interview on 7/9/18, the qualified intellectual disabilities professional (QIDP) revealed no additional training has been provided for client #3 and/or staff since his dental visit on 3/27/18. The QIDP acknowledged more training is needed.	W 350		

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NORTHSIDE GROUP HOME	3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301

(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
W 350	Continued From page 14 2. The facility did not provide ongoing training to staff in efforts to help client #1 improve his oral hygiene rating. Review on 7/10/18 of client #1's dental evaluation dated 12/12/17 revealed his overall dental hygiene rating, "Poor." Client #1 had not received any recent training in efforts to improve his oral hygiene rating. During an interview on 7/10/18, the qualified intellectual disabilities professional (QIDP) revealed staff had not received any specific training on how to better assist client #1 with improving his oral hygiene rating. Further interview confirmed client #1 was in need of oral hygiene training.	W 350		
W 354	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(3) Comprehensive dental diagnostic services include a review of the results of examination and entry of the results in the client's dental record. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure dental record included results of the examination. This affected 1 of 3 audit clients (#2). The finding is: Client #2 did not have the results of her dental examination. Review on 7/10/18 of client #2's dental examination dated 11/7/17 did not reveal any	W 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 354	Continued From page 15 information about the dental examination and her oral hygiene rating. During an interview on 7/10/18, the qualified intellectual disabilities professional (QIDP) revealed client #2 had been been to the dentist, but the results of the examination was not recorded by the dentist. Further interview revealed the dentist's office confirmed the dentist does not provide oral hygiene ratings.	W 354		
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 by staff. During observations at the day program on 7/9/18, the medications were left unlocked and unsecured. The mechanism which was to secured to the wooden frame of the cabinet was not secured and left dangling and not secured to a solid surface. Therefore the medication cabinet and the medications were left unlocked and unsecured until the point of preparation and administration. This allowed for anyone to have easy access to the medications. During an interview on 7/9/18, a staff confirmed	W 382		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 382	Continued From page 16 the medication cabinet should not be left unlocked and unsupervised. During an interview on 7/9/18, a staff confirmed they were unaware medication cabinet lock was not able to be securely locked, because they were not administering the medications. During an interview on 7/9/18, the qualified intellectual disabilities professional (QIDP) confirmed the medications and the medication cabinet should be locked at all times, except for when medications are being administered. During an interview on 710/18, the home manager revealed they were having some repair work completed at the day program which included repairs to the medication cabinet. He further revealed the clients were not left alone to have access to the medications in the cabinet, since the front area is the main area used and a staff is always near.	W 382		