STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G050	A. BUILDING _____ B. WING _____	07/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL SERVICES, INC. RETIREMENT CENTER	**6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705**

(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 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] 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 (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical	E 020		

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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E 020	Continued From page 1 Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuation locations based on a community and facility risk assessment. The finding is: The facility did not have an emergency plan which included evacuation locations. Review on 7/16/18 of the facility's disaster preparedness plan (no date) revealed the plan did not include specific information in regards to the facility's evactuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing residents or other emergencies. During an interview on 7/16/18, staff reported if they did need to evacuate from the facility they would go to a group home which is close by. Further interview revealed the staff did not know the name of the group home. During an interview on 7/17/18, staff revealed if they did need to evacuate they would have to wait for instructions from the on-call person. During an interview on 7/17/18, the management staff confirmed the EP plan did not include any	E 020		

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E 020	Continued From page 2 information pertaining to alternate evacuate locations.	E 020		
W 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure a comprehensive functional assessment (CFA) addressed and identified those skill deficits/needed supports that may be amenable to training in the use of a key to unlock arts and crafts and snacks or other items kept locked in the facility due to specified clients' behavior. This affected 4 of 4 audit clients (#1, #10, #13 and #16) Client #1, #10, #13 and #16 did not have assessments on their abilities to use a key documented. A. Review on 7/17/18 of client #1's individual support plan (ISP) dated 10/27/17 revealed no mention of an assessment of skills in key use. Further review of the record revealed no documentation of an assessment. B. Review on 7/17/18 of client #10's ISP dated 1/3/18 revealed no mention of an assessment of skills in key use. Further review of the record revealed no documentation of an assessment. C. Review on 7/17/18 of client #13's ISP dated	W 214		

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W 214	Continued From page 3 8/10/17 revealed no mention of a self-medication administration assessment. Further review of the record revealed no documentation of an assessment of skills in key use. D. Review on 7/17/18 of client #16's ISP dated 3/28/18 revealed no mention of a self-medication administration assessment. Further review of the record revealed no documentation of an assessment of skills in key use. Interview with two qualified intellectual disabilities professionals (QIDP) on 7/17/18 confirmed there are no documented assessments of key use for any of the residents of the facility. The QIDP also confirmed the supplies (snacks and craft activities) are kept locked due to two individual non-audit behaviors and that the behaviors are addressed in active treatment programs which include the locking of the items.	W 214		
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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure interactions supported the individual program plan (IPP) in	W 249		

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W 249	Continued From page 4 the areas of medication administration guideline implementation. This affected 1 of 4 audit clients (#10). The finding is: Client #10's guidelines were not implemented as written. During observations of the morning medication pass on 7/17/18, client #10 was assisted in punching her pills and she took them all at one time. Review of the record on 7/17/18 revealed medication pass guidelines updated 2018 which indicated she should take one pill at a time. During an interview on 7/17/18, staff confirmed the guidelines are current and should be followed during medication pass.	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 observations, record reviews and interviews, the facility failed to assure that all techniques used to manage behaviors are integrated into an active treatment program. This affected 1 of 4 audit clients (#1). The finding is: The technique of assisting client #1 from losing his hearing aids by locking them in the medication room was not integrated into an active treatment	W 288		

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W 288	Continued From page 5 program. During observations on 7/17/18 , client #1 was observed at 7:00 am to be in the lobby with no hearing aids on. During an interview at 7:00am on 7/17/18 after the observation, client #1 was asked where his hearing aids were and he stated, "I can't get them until after medications." Further observations on 7/17/18 revealed he ate breakfast then got his medications and was given his hearing aids at that time. Staff interview on 7/17/18 revealed she did not know why they were kept locked in the medication room. She stated all hearing aids were kept locked in the medication closet. Interview with the qualified intellectual disabilities professional (QIDP) on 7/17/18 confirmed the hearing aids are kept locked up in the medication administration closet but stated it is because he will lose them. She also confirmed there has not been any formal training goals to address his ability to keep up with the hearing aids since she has been there. Further interview (twice) with client #1 revealed he thinks he could learn how to keep up with his hearing aids but it would be hard.	W 288		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369		

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W 369	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure 1 of 12 morning medications were given without error. This affected 1 of 4 audit clients. (#10) The finding is: Client #10 was not given her Deep Sea nose spray as ordered. During observations on 7/17/18 of the morning medication pass, client #10 received her morning medications. During observations, she held the nose spray to her nose and tipped it up. She did not squeeze the bottle to activate the spray. Review on 7/17/18 of client #10's physician orders signed by the doctor on 4/27/18 noted, "Deep Sea Spray 1 spray in each nostril...." Interview with the staff assisting with medications on 7/17/18 at 7:18am revealed client #10 tips the nose spray like that and when asked if that was acceptable she indicated it was acceptable. Interview with the two qualified intellectual disability professionals (QIDP)/ RN on 7/17/18 confirmed client #10 should have squeezed the bottle to receive a spray in each nostril.	W 369		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications	W 371		

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W 371	Continued From page 7 is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure that decision on having or not having self-administration goals as well as in the establishment of guidelines is based upon accurate, current, valid assessments of the client's skills and potential in self medication administration. This affected 4 of 4 audit clients (#1, #10, #13, #16.) The findings are: Client #1, #10, #13 and #16 did not have self-medication administration assessments documented. A. Review on 7/17/18 of client #1's individual support plan (ISP) dated 10/27/17 revealed no mention of a self-medication administration assessment. Further review of the record revealed no documentation of an assessment. B. Review on 7/17/18 of client #10's ISP dated 1/3/18 revealed no mention of a self-medication administration assessment. Further review of the record revealed no documentation of an assessment. C. Review on 7/17/18 of client #13's ISP dated 8/10/17 revealed no mention of a self-medication administration assessment. Further review of the record revealed no documentation of an assessment. D. Review on 7/17/18 of client #16's ISP dated 3/28/18 revealed no mention of a self-medication	W 371		

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W 371	Continued From page 8 administration assessment. Further review of the record revealed no documentation of an assessment. Interview with two qualified intellectual disabilities professionals (QIDP) on 7/17/18 confirmed there are no documented self-medication administration assessments for any of the residents of the facility.	W 371		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide adaptive equipment during medication administration. This affected 1 of 4 audit clients (#16). The finding is: Client #16 was not provided with his raised cup stand during the medication pass. During an observation of medication administration on 7/16/18, client #16 was provided with a regular cup and straw. He was not provided with any adaptive equipment. During lunch and supper on 7/16/18 and breakfast on 7/17/18, he was provided with a	W 436		

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W 436	Continued From page 9 raised cup stand. Review on 7/16/18 of client #16's individual support plan (ISP) dated 3/28/18 revealed, "...uses adaptive equipment...Drinks independently with raised cup stand...is able to drink any beverage independently with the use of adaptive equipment." During an interview on 7/17/18, staff revealed that client #16 uses his adaptive cup stand "because he likes to hold his cup." Further interview with the Qualified Intellectual Disabilities Professional (QIDP) on 7/17/18 confirmed that client #16 has a cup stand for use whenever he drinks.	W 436		