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STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

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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 7/20/18 of the facility's emergency preparedness (EP) did not include information regarding alternate means of communication. During an interview on 7/20/18, qualified intellectual disabilities professional (QIDP) revealed if the land line phone and cell service were down they were not aware of another way to communicate during an emergency.	E 032		

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

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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 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.	E 036		

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E 036	Continued From page 2	E 036		

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 7/20/18 of the facility's EP manual, it did not include any information on training and/or testing for the staff.

During interviews on 7/19/18, a staff revealed they had received some training they were instructed to go the high school or the Salvation Army, if it occurred during the day time. The staff was unable to indicate where the nearest Salvation Army was and if it had any way of housing anyone during an emergency. However, they did not know where to go if the emergency occurred during the night time or mid morning hours. The staff further revealed they were not tested on this information nor any other emergency preparedness plans.

During interviews on 7/19/18, a staff revealed they had received some training and were instructed to go the high school or the nearest Fire Station. The staff stated they had practiced a natural disaster drill and evacuated to a nearby high school. However, this training information and documentation could not be confirmed nor located by management.

During an interview on 7/20/18, the qualified intellectual disabilities professional (QIDP) confirmed they had no documentation of staff training or testing regarding the emergency

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E 036	Continued From page 3 preparedness plans. He further stated he had not conducted any emergency preparedness training and testing. Additional interview revealed their team had not considered the fact of the emergency occurring during the night after business hours or in the early wee hours of the morning.	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 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.	E 037		

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E 037	Continued From page 4 *[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 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	E 037		

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E 037	Continued From page 5	E 037		

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.
(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,

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E 037	Continued From page 6	E 037		

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 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 7/20/18 of facility documents did not reveal any training inservice sheets for staff in regards to emergency preparedness disaster drills.

During interviews on 7/19/18, a staff revealed they had received some training they were instructed to go the high school or the Salvation Army, if it occurred during the day time. The staff was unable to indicate where the nearest

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E 037	Continued From page 7 Salvation Army was and if it had any way of housing anyone during an emergency. However, they did not know where to go if the emergency occurred during the night time or mid morning hours. The staff further revealed they were not tested on this information nor any other emergency preparedness plans. During interviews on 7/19/18, a staff revealed they had received some training and were instructed to go the high school or the nearest Fire Station. The staff stated they had practiced a natural disaster drill and evacuated to a nearby high school. However, this training information and documentation could not be confirmed nor located by management. During interview on 7/20/18, a staff revealed they only complete the regular assigned drills. This staff was unable to specify any emergency preparedness training they had received from the facility. During an interview on 7/20/18, the qualified intellectual disabilities professional (QIDP) revealed he had not conducted and could locate any information on staff receiving any training specific to the facility's emergency preparedness plan.	E 037		
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	W 249		

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W 249	Continued From page 8 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of diet. This affected 1 of 3 audit client (#3). The finding is: Client #3's diet was not followed as written. During observation of the dinner meal in the home on 7/19/18, client #3 ate a Beef patty (frozen processed), Squash (regular canned), Lima Beans (regular canned), Whole Wheat bread, fruit cup (regular prepackaged), then drank water and juice (regular concentrated). Client #3 had seconds of Lima Beans and two glasses of juice. Client #3 obtained his food from the same serving dishes as his housemates. Client #3 was only encouraged to set the table. Client #3 was not to have any of his meal altered and none of his fluids were measured nor his fluid intake documented after his consumption. Review on 7/20/18 of client #3's physician's orders dated 6/1/18 revealed, "Diet: "HEART HEALTHY, 2gm SODIUM, LIMIT FLUID INTAKE TO 48 - 64oz PER DAY." During an interview on 7/20/18 the dietician confirmed client #3's diet should look different than the other clients' in the home. Client #3 is on 2 grams sodium diet. His diet is a low sodium	W 249		

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W 249	Continued From page 9 and he should not received regular canned foods (without being of low sodium) and try to stay away from processed foods as much as possible. During an interview on 7/20/18, the qualified intellectual disabilities professional (QIDP) confirmed client #3's diet should have been followed. Further interview revealed the team needs to meet with the dietician to discuss how client #3's sodium intake can be tailored to more adequately address his needs. Additional interview confirmed staff are to monitoring client #3's fluid intake and documenting his fluid intake throughout the day.	W 249		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure a sanitary environment was provided to avoid transmission of infections and prevent possible cross-contamination. This potentially affected all clients residing in the home. The findings are: Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination. During medication administration observations in the home on 7/20/18 at 7:11am, client #6 was assisted by staff not wearing gloves. While not wearing gloves the staff assisted with applying pressure and squeezing client #6's finger to	W 454		

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W 454	Continued From page 10 release blood onto his glucometer. The staff did not wear gloves throughout client #6's blood sugar check and the rest of client #6's medication administration. There were gloves in a box located on the shelf above the area where staff and the client #6 were seated during the medication administration. However, the staff did not use any gloves during this observed medication administration. During an interview on 7/20/18, the medication technician confirmed they did not wear gloves and should have while being exposed the client's blood. Further interview confirmed they were trained to used gloves when coming in contact with bodily fluids such as blood. During an interview on 7/20/18, the qualified intellectual disabilities professional (QIDP) confirmed the staff should have worn gloves while assisting client #6 with his medical needs. Additional interview revealed staff were trained to used gloves when they come in contact with bodily fluids.	W 454		