

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

PRINTED: 07/10/2018
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G142 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/03/2018 |
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| NAME OF PROVIDER OR SUPPLIER QUAIL ROOST GROUP HOME, (ICF/MR) | STREET ADDRESS, CITY, STATE, ZIP CODE 102 QUAIL ROOST DRIVE CARRBORO, NC 27510 |
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| (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 |
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| E 006 | <p>Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an emergency preparedness (EP) plan including the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. The finding is:</p> | E 006 | <p style="text-align: center;">DHSR - Mental Health</p> <p style="text-align: center;">JUL 26 2018</p> <p style="text-align: center;">Lic. & Cert. Section</p> | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Delorie Klein</i> | TITLE <i>Director of ICF/IID Services</i> | (X6) DATE <i>7/20/18</i> |
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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 006 | Continued From page 1 The facility did not have an emergency plan based upon risk assessments. Review on 7/2/18 of the facility's current EP plan revealed the plan did not provide specific information in regards to the geographic location of the facility, and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. Interview on 7/2/18 with the qualified intellectual disabilities professional (QIDP) revealed she was not aware of this and would be working to correct this issue with the EP plan. | E 006 | The Supervisor (QP) of the Quail Roost home will develop a specific emergency preparedness plan for it's geographic location and the client's needs, including a community-based risk assessment, utilizing an all-hazards approach. The plan will be approved (and reviewed and updated as needed and at minimum annually by the RSI Safety and Environment of Care Committee. The Safety and Environment of Care Committee will monitor the plan annually. The Director of ICF/ID Services will ensure the plan is updated as needed. | 9/1/18 | |
| E 013 | Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical | E 013 | | | |

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| E 013 | Continued From page 2 emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on interview, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk assessment and their communication plan in case of an emergency evacuation of the clients in the facility. The finding is: During an interview on 7/3/18, with management revealed they did not have policies and procedures specifically for the emergency preparedness plan. However, they have been working to develop these policies and procedures. | E 013 | | | |
| E 032 | Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) | E 032 | The RSI Safety and Environment of Care Committee will develop emergency preparedness policies and procedures in accordance with CFR 483.475(b), considering risk assessment and a communication plan in case of an emergency evacuation of the clients in the facility. The RSI Safety and Environment of Care Committee will ensure the implementation of emergency preparedness policies and procedures, based on RSI's emergency plan. The policies and procedures will be approved by RSI's Management Team and reviewed annually by the Safety and Environment of Care Committee. | 9/1/18 | |

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| E 032 | Continued From page 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 7/2/18 of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication. During an interview on 7/3/18, management 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 | | | |
| E 037 | EP Training Program | E 037 | The RSI Safety and Environment of Care Committee will develop, document, and maintain an emergency preparedness communication plan that clarifies primary and alternate means for communicating with facility staff, and federal, state, tribal, regional, and local emergency management agencies. The communication plan will be approved by RSI's Management Team and reviewed annually and updated as needed by the Safety and Environment of Care Committee. | 9/1/18 | |

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| E 037 | <p>Continued From page 4 CFR(s): 483.475(d)(1)</p> <p>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[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:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(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.</p> <p>(ii) Demonstrate staff knowledge of emergency</p> | E 037 | | | |

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| E 037 | <p>Continued From page 5 procedures.</p> <p>(iii) Provide emergency preparedness training at least annually.</p> <p>(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.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(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.</p> <p>(ii) After initial training, provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(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.</p> <p>(iv) Maintain documentation of all training.</p> | E 037 | | | |

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| E 037 | <p>Continued From page 6</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <ul style="list-style-type: none"> (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. <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <ul style="list-style-type: none"> (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. | E 037 | | |
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| E 037 | Continued From page 7 *[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 interview and record review, the facility failed to assure direct care staff were sufficiently trained on the facility's emergency plan (EP). The finding is: Staff had not received adequate training on the emergency plan (EP). Review on 7/2/18, of facility documents revealed training inservice sheets for direct care staff in regards to fire and disaster drills. Staff interviews (2) on 7/2/18 revealed the following; staff were able to provide the procedures regarding fire drills and disaster drills; however, the staff could not provide specific details regarding any training they received for the facility's EP program. Interview on 7/3/18, with the qualified intellectual disabilities professional (QIDP) revealed she did not have any training for direct care staff specific to the facility's EP. | E 037 | All facility employees will receive initial and annual training in emergency preparedness policies, procedures, and plan. Training will be completed by the RSI Safety and Environment of Care Committee. The HR Department will maintain documentation of the training and ensure completion of the training annually. As part of the training, employees will demonstrate knowledge of the emergency procedures. | 9/1/18 | |
| W 383 | DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) | W 383 | | | |

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| W 383 | <p>Continued From page 8</p> <p>Only authorized persons may have access to the keys to the drug storage area.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure only authorized persons have access to the keys to the medication closet. This potentially affected all clients in the home. The finding is:</p> <p>The key to the medication closet was left assessable.</p> <p>During morning medication administration in the home on 7/3/18, at approximately 7:10am, the medication technician exited the medication room to assist a client with their morning routine. Further observations revealed the medication keys were left on the table unattended. The surveyor was left alone in the medication room, where the closet is located, for approximately 4, minutes.</p> <p>Additional observations medication administration in the home on 7/3/18, at approximately 7:40am, the medication technician exited the medication room to assist a client and left the medication keys on the table unattended. The surveyor was left alone in the medication room, for approximately 2, minutes.</p> <p>During an interview on 7/3/18, with the qualified intellectual disabilities professional (QIDP) confirmed the medication keys should never be left unattended. Further interview revealed all staff have been trained.</p> | W 383 | All employees will be retrained on proper procedures with medication administration including keeping the medication keys secure at all times. The supervisor will monitor follow through by completing observations of medication administration at least monthly. | 7/26/18 | |

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