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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G355	A. BUILDING ______ B. WING ______	07/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD IV	404 SKEET CLUB ROAD HIGH POINT, NC 27265

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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(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:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[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. *[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. (2) Include strategies for addressing emergency events identified by the risk assessment. * [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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop specific facility-based strategies as part of their emergency plan (EP). The finding is: Review of the facility's Emergency Program (EP) on 7/16/18 revealed a thorough risk assessment	E 006		

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 006	Continued From page 1	E 006		

and community-based strategies. Further review of the EP, substantiated by interview with the home manager and qualified intellectual disabilities professional (QIDP), revealed some additional facility-based information needed to be more specific to the needs of the group home and clients in the group home. For example:

A. Review of the EP revealed the storage of emergency supplies in the group home to include flashlights, radios, food and water with no specifics as to the location of supplies. Observations in the home, substantiated by interview with the home manager and facility staff on 7/16/18 revealed food, water, medications, emergency lighting and a two-way radio to be located in the group home. There was no documentation or list of items in the EP to indicate the specific amounts of supplies and where in the home the items were located.

B. Review of the EP revealed information regarding the residents of the group home with each resident's person centered plan (PCP). Further review of the EP and interview with the home manager and QIDP revealed laminated cards to be placed on the client regarding specific identification information, these cards did not specify communication needs or behavior support plan (BSP) information of the 6 residents of the group home to assist anyone unfamiliar with the residents working with them in an emergency situation. Review of records on 7/17/18 revealed 2 of 6 residents of the group home to have speech/language impairment and 2 of 6 residents to have visual impairment. Review of human rights committee minutes for the review year on 7/16/18 revealed 6 of 6 residents of the group home to have formal BSP's.

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E 006	Continued From page 2 Interview with the QIDP on 7/17/18 revealed the facility was working on compiling more comprehensive client specific information and supplies to assist anyone unfamiliar with the clients in working with them in an emergency, however, this information was not currently available.	E 006		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(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.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):]	E 015		

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E 015	Continued From page 3 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: The facility failed to ensure sufficient water supplies were available in accordance with the facility emergency plan (EP) as evidenced by observation, interviews and review of the facility EP. The finding is: Review of the facility's EP conducted on 7/16/18 revealed a list of foods and beverages including 3 large containers of water. Continued review revealed the facility should have a gallon of water per person for a minimum of 3 days. Observations of the emergency food supplies revealed 15 gallons of water were available. Interview conducted on 7/16/17 with the home manager and on 7/17/18 with the qualified intellectual disabilities professional (QIDP), verified by review of records, revealed the facility	E 015		

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E 015	Continued From page 4 houses 6 residents with 2 staff required for first and second shift and 1 staff on night shift. Further interview with the QIDP and further review of the facility EP revealed the facility should have 27 gallons of water on site for emergency purposes. Therefore, the facility has insufficient water supply to meet the facility EP requirements.	E 015		
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 observation, record review, and interview, the team failed to assure a continuous active treatment program was provided for 1 of 3 sampled clients (#2). The finding is: Observations on 7/18/18 from 4:30 PM until 5:20PM revealed client #2 to sit on the living room sofa watching TV until dinner was served at 5:20PM. There was no activity offered client #2 during this 50 minutes except to wash his hands for dinner, nor did he initiate any activity. Observations on 7/19/18 from 7:15 AM until 8:55 AM revealed client #2 to sit on the sofa in the living room without any activity except to talk to staff in the living room, take his morning	W 249		

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W 249	Continued From page 5 medications, drink a bottle of water the staff brought to him, eat a small amount of his breakfast meal, and use the restroom, which took approximately 25 minutes. For the remaining 75 minutes client #2 was observed to sit in the living room watching TV. During this 75 minute period client #2 was asked to participate in emptying the trash and cleaning off his breakfast plate, both of which he refused. There was no other activity or training offered client #2 during this 75 minute period. Review of client #2's record on 7/19/18 revealed a Person Centered Plan (PCP) dated 8/17/17. Review of the current programs for client #2 revealed 2 objectives related to self-care including: drying off his face and brushing his teeth, along with 1 other goal of identifying bills of $25.00. Continued review of the PCP contained a current Adaptive Behavior Inventory (ABI) revealing client #2 is able to perform some of the skills but not all, to accomplish activities of loading the dishwasher, washing dishes by hand, preparing beverages, and emptying the trash. Continued review of the PCP revealed a current Physical Therapy Evaluation which recommended client #2 needs physical activity of greater than 20-30 minutes daily. Interview with the qualified intellectual disabilities professional confirmed that client #2 should not have been sitting idle for approximately 2 hours during the observational periods, but should have been involved in active treatment.	W 249		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3)	W 287		

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W 287	Continued From page 6 Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: The facility failed to ensure techniques to manage inappropriate client behaviors were not used as a convenience for staff for 2 out of 5 residents residing in the group home (#5 and #6) as evidenced by observations, interviews and review of records. The findings are: A. Observations in the group on 7/18/18 at 5:40 PM after dinner revealed client #6 to request shampoo from staff for his nightly shower. Continued observations revealed staff to go to the medication room, get two small sample cups of shampoo and conditioner from the medication room, and give the sample cups to client # 6 for his shower. Interview with the staff revealed the client's shampoo and conditioner are kept in the medication room due to the possibility of client squirting too much shampoo out of a larger bottle. Continued interview with staff revealed client #6 does not require supervision with his shower. Review of the record on 7/19/18 for client #6 revealed a Person Centered Plan (PCP) dated 9/8/17 which stated "client has full access to toiletries and supplies." "Client requires some minimal assistance with bathing and dressing." Interview with the QIDP on 7/19/18 revealed client's toiletries should not be locked in the medication room, or stored in a closet for staff convenience, but should instead be stored in	W 287		

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W 287	Continued From page 7 client #6's room as stated in his PCP. B. Observations in the group home on 7/19/18 after breakfast revealed staff accompanying client #5 to a closet to get his toiletry basket containing toothpaste and a toothbrush and deodorant. Continued observations revealed client #5 took his basket into the bathroom with staff. Further observation revealed client #5 to return his basket to the closet. Interview with staff revealed the client's toiletry basket is stored in the hall closet to prevent client #5 from possibly wasting toiletries such as using too much toothpaste. Continued interview revealed shampoo for client #5 is stored in the medication room and given to the client in sample cups for his use. Further interview with staff revealed that this practice is utilized to prevent client #5 from possibly squirting too much of the shampoo out of the bottle when he showers. Review of the record on 7/19/17 for client #5 revealed a (PCP) dated 8/15/17 which stated "accessibility to his toiletries: client keeps his personal possessions in his bedroom. Staff assists getting additional materials as they are needed-client requires some monitoring and some assistance with bathing and dressing." Interview with the QIDP on 7/19/18 revealed client's toiletries should not be locked in the medication room, or stored in a closet for staff convenience, but should instead be stored in client #5's room as he PCP states.	W 287		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)	W 436		

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W 436	Continued From page 8 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 observation, record review and interviews, the facility failed to provide, maintain and teach the client to use prescribed eyeglasses for 1 of 3 sampled clients (#6). The finding is: Observations conducted throughout the recertification survey conducted on 7/16/18 and 7/17/18 revealed client #6 ate supper and breakfast, watched television, obtained the client lunch bags and program books and loaded them onto the facility van preparing to leave for the vocational center. Client #6 was not observed to be wearing eyeglasses at any time and no eyeglasses were observed to be available for client #6. Review of the record for client #6 revealed a person centered plan (PCP) dated 9/8/17. Review of the PCP revealed training objectives including walking, flossing, sweeping, loading the dishes and stating personal information. Further review of the record for client #6 revealed a nursing quarterly dated 7/31/17 revealed client #6 requires eyeglasses but will break them as soon as they are on. A opthalmology consultation dated 8/4/17 documented a diagnosis of hyperoptic astigmatism with no change in the eyeglasses prescribed.	W 436		

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W 436	Continued From page 9 Interview conducted on 7/17/18 with the nurse revealed the location of client #6's eyeglasses is currently unknown. Interview with the qualified intellectual disabilities professional (QIDP) verified client #6 has no eyeglasses and no training objective has been developed to address the use and care of eyeglasses for client #6.	W 436		