STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

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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 interviews and reviews, the facility failed to assure policies and procedures outlined a primary and alternate means for communication with external sources for assistance. This potentially affects all individuals residing in the facility. The finding is: The facility failed to establish a written communication plan for emergencies. Review on 8/20/18 of the facility emergency preparedness plan revealed there was no communication plan outlining primary and alternate means of communication. Interview with the qualified intellectual disabilites professional (QIDP) on 8/20/18 and 8/21/18 confirmed the facility does not have a written communication plan defining primary and alternate means of communication.	E 020		
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 2 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 1 of 3 audit clients (#1's) meal time guidelines were consistently implemented as they were written in the individual program plan (IPP). The finding is: Client #1's mealtime guidelines were not consistently implemented as written. During observations of dinner on 8/20/18 and at breakfast on 8/21/18, staff fed client #1 using a dry spoon between some bites. However liquids were not provided to her between bites. For example, at dinner the staff used a dry spoon between every bite but did not give her liquids between every bite. At breakfast, the staff used a dry spoon to facilitate swallows when client #1's mouth was full. She also did not provide liquids between bites. Review on 8/20/18 of client #1's IPP dated 9/4/17 revealed recommended guidelines for feeding her. The guidelines noted staff should alternate liquids and solids. Interview with the group home manager on 8/21/18 confirmed liquids should have been consistently alternated with solids during all meals.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)	W 368		

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W 368	Continued From page 3 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure all medications were kept locked up to the point of administration. This potentially affected all clients residing in the facility. The finding is: The medications were left unlocked and unattended by staff. During observations of the morning medication pass on 8/21/18, at 6:55am, the staff left the area with a client in the room. He headed toward the kitchen. In an interview before the staff walked out on 8/21/18, he told the surveyor he was leaving. the surveyor stated, "Act as if I am not here." He replied, "Okay" and left. During observation of the room after he left, the door to prn medications was unlocked with numerous medication packs on the shelves. When the staff returned after a few minutes, he was asked if he always left the client in a room with unlocked medications in that closet. He stated that the closet is usually locked and he locked it back Interview on 8/21/18 with the qualified intellectual disabilities professional (QIDP) confirmed medications should be kept locked and that staff should not leave an area with medications unlocked.	W 368		

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