STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G111	A. BUILDING _____ B. WING _____	09/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILOTVIEW	209 PILOT VIEW DRIVE KING, NC 27021

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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 record review and interviews with staff and verified by the qualified intellectual disabilities professional (QIDP), the facility failed to develop a thorough risk assessment to ensure the emergency preparedness plan (EP) was specific to the facility utilizing an all hazards approach and developing policy and procedures relative to the	E 006		

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

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E 006	Continued From page 1 specific needs of the clients. The finding is: The facility did not have an emergency preparedness plan (EP) based upon a risk assessment. Review on 9/4/18 of the facility's current EP revealed it was written in a general way to accommodate the needs of the facility and did not provide specific information in regards to the geographic location of the facility and the needs of the clients. A. Review on 9/4/18 of the EP did not reveal the highest potential emergency disasters facing the group home and included general information for each type of weather disaster. Further review of the EP did not reveal information regarding the highest potential emergency or encompass potential hazards. B. Record review on 9/4/18 did not reveal information regarding the residents of the group home including specific needs of the 5 residents in the group home to assist anyone unfamiliar with the residents working with them in an emergency situation. Interview on 9/5/18 with the QIDP substantiated facility based information needed to be developed to address site specific emergency disasters, potential emergencies based on potential hazards and the specific needs of the clients in the group home.	E 006		
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(a) Emergency Plan. The [facility] must develop	E 009		

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E 009	Continued From page 2 and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on review of the emergency preparedness plan (EP) and interview substantiated by the qualified intellectual disabilities professional (QIDP), the facility failed to reveal contact information and collaboration with local EP officials in an effort to maintain an integrated response during a disaster or emergency situation. Review on 9/4/18 of the EP revealed a list of	E 009		

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E 009	Continued From page 3 phone numbers with names of people and places and did not include specific instructions to contact EP officials related to the facility. Further review did not reveal collaborative information involving local EP officials.	E 009		
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.	E 020		

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E 020	Continued From page 4 * [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 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 interview with the qualified intellectual disabilities professional (QIDP) and interviews with staff, the facility failed to develop specific policies and procedures to address the emergency preparedness plan (EP), such as developing a communication plan for evacuation and consider alternative emergency evacuation sites based on a risk assessment in case of a need for an emergency evacuation of clients residing in the facility. The facility did not include a specific detailed communication plan and relocation plan with alternate relocations within their EP. Review on 9/4/18 of the facility's EP revealed relocation may be necessary for the safety of the individuals and a list of names and locations with phone numbers to contact. Further review of the EP did not include specifics about relocation site(s) for the clients nor the communication between staff, client guardians or any other entity. Interview with the QIDP confirmed there was no	E 020		

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E 020	Continued From page 5 specific information regarding communication and relocation of clients in the event of an emergency.	E 020		
E 029	Development of Communication Plan CFR(s): 483.475(c) (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. This STANDARD is not met as evidenced by: Based on record review on 9/4/18 and substantiated by interview with the qualified intellectual disabilities professional (QIDP), the facility failed to assure the emergency preparedness plan (EP) included a communication plan with both a primary and alternate means of communication with external sources of assistance. The facility did not have a communication plan as part of the emergency preparedness policies and procedures. Review of the facility policies and procedures revealed only phone numbers for external sources. There was no information on how communication should be done and there was no back up communication plan.	E 029		