STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G221	A. BUILDING _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY AVENUE HOME	112 HICKORY AVENUE HOLLY SPRINGS, NC 27540

(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
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. The finding is: Facility management staff failed to develop specific strategies to address the possible hazards to the clients who reside in the facility	E 006		

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

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E 006	Continued From page 1 given an emergency situation. Review on 9/10/18 of the facility's emergency management plan revealed there was no thorough assessment of the hazards and risks given the geographic area of the facility. There was general information in this plan about power outages and bomb threats, however there was not specific information for the direct care staff at the facility about the possible hazards that may occur given the location of the facility. Interview on 9/10/18 with facility management staff revealed there had not been an all hazards risks assessment completed for this facility.	E 006		
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):]	E 020		

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E 020	Continued From page 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 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 staff interviews, 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 findings are: Facility Management failed to develop a specific plan for the clients to relocate outside of the facility and to include this information in their disaster plan.	E 020		

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E 020	Continued From page 3 Review on 9/10/18 of the facility's disaster preparedness plan dated 6/1/16 did not include specific information in case of flood, fire, tornadoes, hurricanes, winter storms and bio terrorism. Interviews on 9/10/18 with direct care staff (2) revealed no knowledge of an emergency preparedness plan (EMP). When interviewed, management staff did have an understanding of the facility's disaster plan. When asked where clients would be relocated, she stated the local high school. She stated there was no written agreement or contact person. She also confirmed this information was not located in the EMP. During an interview on 9/10/18, management staff acknowledged their disaster plan had been updated however it does not include all of the components outlined in the emergency preparedness plan including a risk assessment and an agreement with any shelter or alternate location for the clients to relocate in the event of an emergency.	E 020		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to assure privacy for 1 of 4 audit clients (#1) during dressing. The findings are:	W 130		

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W 130	Continued From page 4 Staff failed to assist client #1 in maintaining his privacy during dressing. During observations on 9/10/18 at 5:52pm client #1 came out of the bathroom naked and walked to the end of the hallway. Direct care staff walked over to client #1 and verbally cued him to go to his bedroom. Client #1 walked to his bedroom naked. When client #1 walked into his bedroom, direct care staff followed him. The bedroom door was open. Direct care staff verbally cued client #1 to get dressed. Clients #3 and #4 walked to the bathroom to wash their hands in full view of client #1's bedroom across the hallway. At 6:05pm client #1 walked out of the bathroom with staff . Review on 9/11/18 of client #1's Community Home Life Assessment dated 11/10/17 revealed client #1 is dependent on staff to assist him with having an awareness of his privacy. Review on 9/11/18 of client #1's individual program plan (IPP) dated 12/5/17 revealed he has a written training objective to close the bathroom door while he is using the bathroom with 70% Independence for 3 consecutive months. This goal was implemented on 8/1/18. Interview on 9/11/18 with the qualified intellectual disabilities professional (QIDP) revealed staff should integrate client #1's need to protect his privacy in all settings. Further interview revealed direct care staff should assist client #1 by closing the door whenever he is dressing.	W 130		