STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G116	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MAIN STREET FACILITY-CARRBORO	1003 W MAIN STREET CARRBORO, NC 27510

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E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(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 9/20/18 of the facility's emergency preparedness (EP) did not include information regarding appropriate alternate means of communication. During an interview on 9/20/18, management revealed if the land line phone and cell service were down the only other thing could be used was a runner to communicate during an	E 032		

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

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E 032	Continued From page 1 emergency.	E 032		
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] 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: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and interviews with staff, the facility failed to develop a method for sharing their Emergency Preparedness Communication Plans as deemed appropriate with the clients residing in the facility and their guardians/representatives. The findings include: The facility did not share their Emergency Preparedness Communication Plans with the clients' and their guardians/representatives. Review on 9/20/18 of the facility Emergency Plans the plans did not include specifics about how the Emergency Preparedness communication plans would be shared and communicated to the clients' and their guardians/representatives. The was no documentation available to review to indicate any information about their Emergency Preparedness had been shared and discussed with any of the the clients' and their guardians/representatives.	E 035		

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E 035	Continued From page 2 During an interview on 9/20/18, management confirmed they had not discussed nor presented any emergency preparedness information to any the clients' and their guardians. During an interview on 2/6/18, management acknowledged they are still making needed adjustments to their plans.	E 035		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (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. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[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: (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. (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 3 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (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. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (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. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (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. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

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E 037	Continued From page 4	E 037		

arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(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.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(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.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(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,

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E 037	Continued From page 5 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. *[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 interviews and record review, the facility failed to assure direct care staff were adequately trained on the facility's Emergency Preparedness policies and procedures. The finding is: Staff were not adequately trained and tested on the facility's Emergency Preparedness plans. During an interview on 9/19/18, staff revealed they had received some training on fire and tornado drills. However, they had not received any training on the facility's emergency preparedness plans. During an interview on 9/20/18, staff revealed they had received training on fire and tornado	E 037		

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E 037	Continued From page 6 drills, what to do and where to go. However, they had not received any training on the any Emergency Preparedness. Further interview revealed training on real emergencies and on evacuations would be helpful. During an interview on 9/20/18, staff revealed they would have to call administration for instructions and where to evacuate. Further interview revealed they had not received any training on Emergency Preparedness, it would be helpful. During an interview on 9/20/18, management revealed they had talked about Emergency Preparedness during staff meetings. Review on 9/20/18 of facility's emergency preparedness plans notebook revealed no documentation of staff training on the facility's emergency preparedness plans. There was no documented information from any staff meetings to indicate the topic of Emergency Preparedness: discussion, questions, concerns, changes, testing etc. presented to indicate the facility had conducted any emergency preparedness training.	E 037		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure a sanitary environment was provided to avoid transmission of infections and to prevent possible cross-contamination. This	W 454		

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potentially affected all clients residing in the home. The findings are:

Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination.

1. During observations in the home on 9/19/18 at 4:23p, staff whisked away the facility's cat away from the table. The cat continued to jump from one seat to another at the dining room table, so the staff obtained a spray bottle of water and sprayed the water on the cat, the cat ran away from the table. As a client was setting the table for dinner the cat climbed into a chair at the dining table and started sniffing two plates on the table. The cat's name was called, then the cat moved from chair to chair at the table and staff obtained him and he jumped onto the floor. During dinner as the clients were eating at the dining room table, the cat went into the kitchen jumped onto the counter and stove began sniffing the food in the serving bowl, pot and the Garlic bread left on the pan and licked the pot handle. Then cat put its face into the green pea serving dish which had a small amount of green peas in it and licked the bowl. Then the cat placed its face into the chicken stir fry and obtained some chicken. The surveyor asked the staff did they know the cat was on the counter and stove, eating out of the serving dishes and pot. The staff left the table, went into the kitchen whisked the cat away, put the dishes in the sink and covered the extra Garlic bread with foil and left it on the stove. There were two clients who had gone on an outing and the Garlic bread was left for their dinner.

2. During observations in the home on 9/20/18 at

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W 454	Continued From page 8 6:30am, staff opened the entrance door wearing disposable gloves. The staff stated she was assisting a client with bathing. The staff returned to work with the client. Additional observations in the home on 9/20/18, a client used the bathroom next to his bedroom to brush his teeth with staff monitoring throughout this task. The client used the sink while brushing his teeth, he spit into the sink several times and afterwards the client ran water, which filled the sink bowl, he put his hands down into the water and swished his hands in the water. The client was asked to wash his hands which he complied. Then the staff, while not wearing gloves, obtained a paper towel and proceeded to wash the dirty sink with only water, no disinfectant was used. This sink was used immediately after the first client. The second client was monitored as used the sink to brush her teeth. After she brushed her teeth wash her hands and wiped her mouth, she used the same paper towel she wiped her mouth to wipe the counter of the sink. The sink was not disinfected after each known toothbrushing tasks. The sink was not disinfected before nor after a client used the sink for toothbrushing purposes. During an interview on 9/20/18, staff confirmed they came to the door wearing gloves they were wearing while they were assisting a client with bathing needs. The staff further stated they did not wear gloves while they cleaned the sink with only water and was aware of the client spit into the sink. Further interview revealed disinfecting of the sink and other items, is done at night and not when the clients are up. Additional interview revealed they were trained to wear gloves during personal care bathing and when coming in contact with bodily fluids and blood.	W 454		

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W 454	Continued From page 9 During an interview on 9/20/18, the qualified intellectual disabilities professional (QIDP) revealed they only use Vinegar and water to disinfect. The staff should have used gloves while cleaning. Further interview confirmed it is not in their policy to use Vinegar as an disinfectant. Further interview confirmed the cat should not have been on the counter nor stove. During an interview on 9/20/18, management confirmed staff are trained when to use and remove gloves. She revealed staff were not trained to clean/disinfect in between each client. Further interview revealed staff are to be monitoring the cat, that is why they have a spray bottle.	W 454		