STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	08/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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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 observations, record review and interviews, the facility failed to develop specific facility-based strategies as part of their emergency preparedness plan. The finding is: A. Review of the facility's emergency preparedness plan (EP), conducted on 8/6/18	E 006	IDT will ensure the facility's emergency response plan includes basic inventory of emergency supplies and comprehensive information regarding the needs of individual clients residing in the home. QP will ensure all staff are in-serviced trained on the emergency plan to include any updated information. IDT will continue to train on the emergency plan at least quarterly and/or with new staff. IDT will monitor with quarterly safety checklist. DHSR NH L&C Black Mountain WRO Received AUG 23 2018 by: SKH	10-6-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/22/18

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 revealed identified risks including power outages, inclement weather, and shelter in place strategies, among others. Observations conducted in the home on 8/6/18-8/7/18 revealed an inadequate supply of food and water available in the home to support risks identified in the EP. Interviews conducted with staff in the group home as well as with the qualified intellectual disabilities professional (QIDP) revealed no basic inventory of emergency supplies had been developed and or maintained as part of the current emergency plan. B. Review of the EP revealed information provided regarding individual residents of the home was limited to the general information on the face sheet, as well as prescribed diet information. Continued review revealed there was no comprehensive, client specific information included in the EP which would inform persons working with the clients during an emergency situation who were unfamiliar with each client's communication and behavioral needs, along with interventions and supports required for activities of daily living.	E 006		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: The facility failed to assure the individual habilitation plans (IHPs) for 3 of 6 clients in the	W 227	IDT will ensure the individual habilitation plans include training to meet the client needs which includes the needs for fire evacuation drills. Habilitation will develop formal training to address the needs regarding evacuation during fire drills for client #1, #5 and #6 and in-service train staff. IDT will monitor with weekly observations until issues are resolved. For future, IDT will continue to monitor with monthly assessments.	10-6-18

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W 227	Continued From page 2 home (#1,#5,and #6) included objective training to meet the clients' needs as evidenced by review of the facility fire evacuation drills and interviews with facility staff. The findings are: A. The facility failed to assure objective training was developed to meet client #1's fire evacuation needs. Review of the facility evacuation reports for the past year revealed third shift drills were conducted 9/4/17, 1/8/17, 3/3/18, and 6/6/18. Continued review of the fire drill reports revealed on 6 /6/18 client #1 followed the staff in and out of the home refusing to stay in the designated safety area outside of the home. The fire evacuation drill took 12 minutes to complete which is approximately 10 minutes beond the normal time for evacuation. Review of client #1's 9/22/17 Person Centered Plan (PCP), substantiated by interview with the qualified mental health professional revealed no formal training has been developed to address client #1's need. B. The facility failed to assure objective training was developed to meet client #5's fire evacuation drills needs. Review of the facility evacuation reports for the past year revealed third shift drills were conducted 9/4/17, 1/8/17, 3/3/18, and 6/6/18. Continued review of the fire drill reports revealed client #5 refused to particiapte in the fire drill by sitting in the floor and screaming during the evacuation drill. Further review of the report revealed client #3 finally exited the home but would not stay in the designated safe area outside the home. Instead client #5 continued to follow the staff in and out of the home as staff assisted other housemates' exit from the home. Review of client #1's 12/15/17 Person Centered Plan (PCP), substantiated by interview with the qualified mental health professional revealed no	W 227		

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W 227	Continued From page 3 formal training has been developed to address client #5's need. C. The facility failed to assure objective training was developed to meet client #6's fire evacuation drills needs. Review of the facility fire drills reports revealed the 1st shift drills were held on 10/3/17, 1/5/18, 4/17/18, and 7/5/18. Continued review of the group home fire drill reports revealed client #1 refused to participate in the fire evacuation in the home on 1/5/18. He instead lay on the floor of the group home refusing to particiapte, cursing and hitting the staff as reported on the fire drill report on 1/5/18. The fire drill evacuation took 22 minutes to complete, twenty minutes beyond the normal time of evacuation. Review of client #6's current Person Centered Plan (PCP), substantiated by interview with the qualified mental health professional revealed no formal training has been developed to address client #6's current need to evacuate the group home safely.	W 227		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: The facility failed to assure the medication closet door was kept locked as required as evidenced by observation and interview. The finding is: Afternoon medication observations in the group home at 6:10 PM on 8/6/18 revealed the	W 382	Nursing will in-service train staff on Medication Administration policies and procedures to include the medication closet should be locked except when preparing for administration. IDT will monitor with weekly observations until issues are resolved. For future, IDT will continue to monitor with monthly assessments and QA.	10-6-18

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W 382	Continued From page 4 medication closet containing all client medications to be unlocked along with the medication refrigerator located within the medication closet. Interview with staff administering afternoon medications on 8/6/18 at 6:30 PM verified the medication closet door, along with the medication refrigerator in the closet, were left unlocked but should have remained locked except when giving medications. Interview with the facility nurse confirmed the medication closet as well as all medications should be kept locked except when being prepared for administration.	W 382		