DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G294	A. BUILDING _____ B. WING _____	09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KONNOAK GROUP HOME	2901 KONNOAK DRIVE WINSTON SALEM, NC 27127

(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 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(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:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: The facility failed to assure their Emergency Plan (EP) contained specific information regarding 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6) as evidenced by interview and record verification. The finding is: Review of the facility's EP on 9/5/18 revealed no information regarding the clients in the home to be included in the EP. Further review of the EP, substantiated by interview with the qualified intellectual disabilities professional (QIDP) on 9/6/18, revealed the facility failed to develop specific information for the EP regarding client needs, preferences, behaviors, means of communication, ambulation or other important information to assist those helping the clients during an emergency. Continued interview with the QIDP revealed the EP was only developed for the group home around 5/18 and has not been fully developed as needed.	E 007	See attached DHSR NHL & C Black Mountain MRO Received SEP 18 2018 by: SKH	9/14/18
E 009	Local, State, Tribal Collaboration Process	E 009		

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 009	Continued From page 1 CFR(s): 483.475(a)(4) [(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:] (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: The facility failed to develop an Emergency Plan (EP) which included a process for cooperation and collaboration with local, state and federal emergency preparedness officials' efforts integrated emergency response or documentation of the facility's efforts to contact such officials as evidenced by interview and record verification.	E 009	See attached	11/6/18

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E 009	Continued From page 2 The findings are: Review of the facility's EP on 9/5/18 revealed a letter dated 5/1/18 from location in another county where other sister group homes are located noting the group home has permission to use a facility for shelter needs whenever it needs to evacuate. Interview with the qualified intellectual disabilities professional (QIDP) on 9/6/18, substantiated by further review of the EP, revealed that although they have a place to go out of county if needed, no contact has been made with local emergency management resources to determine what is available locally in case evacuation is not possible. Continued interview and review of the EP revealed the plan was only developed by the facility as of 5/18 and has not been totally completed. For example, information regarding resource center telephone listing is a general form that has not been filled out specific to the group home.	E 009		
E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] 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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030	See attached	11/16/18

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E 030	Continued From page 3 (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following:	E 030		

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E 030	Continued From page 4 (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: The facility failed to develop an Emergency Plan (EP) that included a complete communication plan as evidence by interview and record review. The finding is: Review of the facility's EP on 9/5/18 revealed a general emergency plan that did not contain information specific to the home. For example, review of the EP revealed information sheets regarding staff phone and addresses, staff recall procedures, and staff functions during an emergency to be left blank or not included in the EP. In addition, information specific to the clients in the home such as physicians or other entities providing services to the clients were not listed in the EP as required. Interview with the qualified intellectual disabilities professional (QIDP) revealed the EP was only developed for the group home in 5/18 and was not complete.	E 030		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: The facility failed to assure medications	W 369	See attached	11/16/18

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W 369	Continued From page 5 administered to 1 of 3 sampled clients (#3) was administered without error as evidenced by observation, interview and record verification. The finding is: Morning observations of the medication pass on 9/6/18 at 7:17 AM revealed staff administering client #3 his morning medications which was noted to include a new medication Zelboraf 240 mg. Client #3 during the medication pass was observed to take 1 tablet. Interview with the facility nurse, substantiated by review of client #3's 9/4/18 physician's orders revealed the client should have received Zelboraf 240 mg. 2 tablets during the morning medication pass. The facility failed to assure client #3's Zelboraf was administered as prescribed.	W 369		

E007 – The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.

Correction:

The facility will ensure all emergency plan pertaining to the individual information such as their needs, preference, behaviors, means of communication, ambulation and any additional information that is useful is stored in their personal emergency bookbag and emergency disaster manual. The QP will be responsible for assuring all emergency manuals are updated and stored properly in their bookbags and emergency clinical books. The QP will be In-Service to make sure all changes relating to the emergency manual regarding their personal information are updated as their needs changes throughout the year. The Operation Manager will meet on a quarterly basis to make sure all parties involved all updating each individual information correctly.

Projected Completion Date: November 16, 2018
Responsible Parties: Qualified Professional, Operation Manager

E009 – Local, State, tribal Collaboration Process

The facility will develop and maintain an emergency preparedness plan that will be reviewed, and updated annually. Konnoak Group Home will network with local, tribal, regional, state, and federal emergency. Konnoak Group Home will have these following networks with Triad Healthcare Preparedness Collation, Forsyth County Emergency Management, and Femma, for contacts if an emergency disaster occurs. All emergency contact networking will be listed in the emergency book specific to the home. The Qualified Professional and Group Home Manager will be In-service to make sure all manuals are updated every year with the correct updated emergency numbers contact. The Operation Manager will complete 1 home observation monthly to monitor both practice and systems of corrections.

Responsible Parties: Qualified Professional, Group Home Manager, Operation Manager
Completion Date: November 16, 2018

E030- Names and Contact Information

The facility will ensure all emergency preparedness communication plan complies with federal, state and local laws and will be updated annually. The communication plan will list all staff who's working with the induvial phone number and address on the emergency communication plan. All individual's will have their most updated physician order and other providing services listed in the communication book. The communication book will be stored in the emergency manual and a copy listed in their personal emergency bookbags for safety precaution pertaining to a disaster. The QP and Group Home Manager will be In-service on keeping and collecting all communication emergency information updated annually. The Operation Manager will complete 1 home observation monthly to monitor both practice and systems of corrections.

Projected Completion Date: November 16, 2018
Responsible Parties: Group Home Supervisor, Qualified Professional, Operation Manager

W369- The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

All medications will be administered in compliance with the physician's order. The facility will ensure staffs are in-serviced on proper administration of medication by RN. The Group Home Supervisor and Qualified Professional will observe the home once a week during home observation and complete a medication observation form. Direct care staff will receive additional in-servicing on how to read the MAR correctly and receive additional medication training. The RN will monitor the MAR monthly for accuracy.

Projected Completion Date: November 16, 2018
Responsible Parties: Nurse, Group Home Supervisor, Qualified Professional