STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G020	A. BUILDING _____ B. WING _____	C 09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUSE'S GROUP HOME	5949 NC 135 STONEVILLE, NC 27048

(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: Based on document review and interviews, the facility failed to develop specific facility based strategies as part of the emergency prepardness plan. The finding is: Review of the facility's Emergency Plan (EP) on 9/24/18 revealed the EP to contain a risk assessment and community strategies. However, further review of the EP substantiated by interview with the facility administrator and the qualified intellectual disabilities professionals (QIDPs) on 9/25/18 revealed that the EP was written in a more general way to accommodate all of the group homes owned by the facility. Continued review of the EP on 9/25/18 confirmed additional facility based information is needed to address the specific needs of each home and the individuals of the homes. For example, the EP revealed no information regarding the specific needs of each of the residents living in each of the 5 homes, to assist anyone who did not know	E 007	The QPs added client specific information from client's IHPs to address the specific needs of each home and the individuals of the homes. The Emergency Management Director and QIDP have modified client specific communication sheets to assist responders/volunteers/medical personnel etc. on the needs and strategies for each client living in homes 1 through 5. These sheets will address the following individualized client's needs listed within their EP: • communication deficits, • mobility needs, adaptive equipment, • special diets, and • behavioral plans Each client specific information sheet (Consumer Emergency Information Form) will be updated to EP Plan books in homes1 - 5. The operations manager, emergency preparedness coordinator and safety committee will perform risk assessment review to ensure The EP booklets in homes 1 - 5 contains client specific communication.	09/25/28 10/11/18 11/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra G. Rouse — TITLE: Executive Director — (X6) DATE: Oct. 13, 2018

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 007	Continued From page 1 the clients. Interview with the QIDPs on 9/25/18 confirmed that many residents of the facility have communication deficits, mobility needs, adaptive equipment, special diets, and behavioral plans that must be addressed. Further interview with the QIDPs on 9/25/18 confirmed specific strategies for each client must be planned for, individualized, and documented specifically to address each client's needs within the EP. Subsequent interview on 9/25/18 with the facility QIDPs confirmed each home currently does not have, but requires an EP Plan book which contains client specific information which remains in the home, and which all staff are familiar.	E 007		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [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: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015	The Emergency Disaster Committee will modify the EP Policy and Procedure to clarify staff's access to sufficient food and water availability in each group home as per the Emergency Plan (EP). RGH EP for houses 1 - 5 contains several emergency storages including a walkin commercial freezer and 3 full kitchens in the basement areas of the homes to provide foods for 6 clients and 2 staff for three plus days. In the event of a shelter in place emergency, provisions to access the storage area in the basements of the residences will include but are not limited to the following personnel:	09/25/18 09/25/19 09/25/18

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E 015	Continued From page 2 safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: The facility failed to ensure sufficient food and water were available in the group homes as per the Emergency Plan (EP) as evidenced by observations and interview. Review of the facility EP revealed that each home should have emergency food and water within the home to provide for 6 clients and 2 staff for three days..	E 015	(1) Supervisor(s) on Site (2) Neighbor (5820 NC Hwy 135, Stoneville) (3) Maintenance Personnel (4) Associate QIDP (5) Operations Manager (6) Emergency Preparedness Coordinator (7) Designated Staff Water, staples and adequate canned goods designated for emergencies are located in each home (House 1-5) as well as within the storage facility. I Policy and procedure will include process for group home staff members to have access to the extra food in the industrial freezer and the basement food storage areas.	09/25/18 09/25/18 09/25/18

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E 015	Continued From page 3 Observations in the group homes on 9/24/18 revealed there was no water or food designated for an emergency in any of the homes of the facility. Continued observations revealed a large refrigerator/freezer building that was approximately 50-100 yards from the homes containing a large storing of refrigerated food items to include meats,vegetables, milk, eggs and other cold food items enough for all of the homes on the facility. Further observation on 9/24/18 revealed a large basement area approximately 50-100 yards from the homes with adequate canned goods for the facility. Continued observations at 5:30 PM on 9/24/18 revealed both of these areas of stored food remained locked and could only be assessed via the facility director or QIDP per interview with the QIDP. Subsequent observations on 9/25/18 revealed a staff member stocking each home with a tub of emergency food as a result of this survey. However emergency water supplies were not observed to be present in the homes on 9/25/18. Interviews with the staff, QIDP, and facility administrator on 9/25/18 confirmed that group home staff members currently do not have access to the extra food in the refrigerated room or the basement area of food and have to call the administrator or QIDP to obtain food currently during an emergency. Continued interview with the QIDP confirmed that emergency bins of food were currently being stocked today in each home as a result of this survey.	E 015		
W 000	INITIAL COMMENTS No deficient practices were cited during the complaint investigation intake #NC 00143184.	W 000		

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W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the team failed to ensure an objective to wear eyeglasses was implemented with sufficient frequency to support the achievement of the objective for 1 of 4 sampled clients (#25). The finding is: Observations throughout the survey conducted from 9/24/18 to 9/25/18 revealed client #25 did not wear eyeglasses. Continued observations revealed at no time did staff prompt client #25 to wear her eyeglasses. Review of records on 9/25/18 for client #25 revealed she was admitted 8/21/18. Continued review revealed an individual program plan (IPP) dated 9/19/18 with a vision exam dated 8/16/17 with "continue with current glasses" and "RTC - 1 yr/PRN." Further review of client #25's IPP revealed training objectives for oral care, household chore completion, medication, safety awareness, and wearing eyeglasses all day for 2 of the last 3 periods by August 31, 2019. Interview with the qualified intellectual disabilities	W 249	The Direct Support Professionals for Client (#25) received in-serviced training on implementing continuous active treatment of all training objectives, including objective to wear eye glasses. During weekly observations, the QP, Associate QP, Lead Staff and Nursing Staff will monitor client #25 to ensure glasses are worn in accordance to the prescribing dr.'s recommendation and/or training objective. Monthly, the interdisciplinary team will review training objectives and discussion w/ staff and client #25 to ensure client is making progress training objective to wear eyeglasses. Changes will be made as needed if program need to be modified. Globally, the QP, Associate QP, Lead Staff and Nursing Staff will complete bi-weekly observations in Rouses (Houses #1 - #6) to ensure all clients' training objectives are implemented as written. Clients will be prompted to wear adaptive equipment as prescribed by their prescribing physician and/or as indicated in their training objectives.	10/11/18 10/19/18 10/31/18 11/19/18

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W 249	Continued From page 5 professional (QIDP) verified client #25 needs to wear her eyeglasses and she has a vision exam scheduled on the afternoon of 9/25/18. Continued interview with the QIDP verified staff should have conducted client #25's program to prompt her to wear eyeglasses as indicated.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: The facility failed to include medications for behaviors in a behavior support plan (BSP) for 1 of 6 sampled clients (#18) as evidenced by interview and review of records. The finding is: Review on 9/25/18 of client #18's individual program plan (IPP) dated 5/9/18 revealed he takes Zyprexa and Clonidine for behavior management since admission on 4/12/18. Review of the current physician's orders dated 9/1/18 to 9/30/18, verified by interviews with the qualified intellectual disability professional (QIDP) and the nurse, revealed the client has been getting these meds since admission. Additional review of the records revealed a behavior support plan (BSP) dated 8/4/18. Verification by the QIDP revealed there was no BSP on admission to include medications for behaviors. Therefore, the facility failed to include the Zyprexa and Clonidine in a behavior plan and medications were administered without a BSP in	W 263	Client #18 has a current consent for medications used for behavior management. Client #18 also has a current BSP consent that includes medications administered for behaviors. Upon admission, clients that take medications for behaviors will have a consent for medications used. These medications used for behaviors will be included in a BSP that addresses behaviors.	08/12/18 08/12/18 10/08/18

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W 263	Continued From page 6 place for client #18 from 4/12/18-8/4/18.	W 263		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: The facility's system for ensuring drugs were administered in compliance with physician's orders failed for 1 of 4 sampled clients (#15) observed as evidenced by observations, interview and review of records. The finding is: Observations in the group home of medication administration on 9/24/18 at 5:25 PM revealed client #15 received a Turpentine 5 mg tablet by mouth. Continued observations at 6:00 PM revealed client #15 sitting at the dining table eating her supper meal which consisted of broccoli, chicken & cheese casserole, a biscuit and fruit cocktail. Review of the physician's orders dated 6/1/18 to 6/30/18 and signed by the provider 6/28/18 revealed client #15 is to receive "Turpentine 5 mg tab by mouth twice daily after meals." Continued review of the 6/1/18 to 6/30/18 physician's orders and verified by another medication technician and the qualified intellectual disabilities professional (QIDP) revealed client #15 should receive the Fluphenazine 5 mg tab by mouth twice daily after meals as prescribed.	W 368	A medication error report was written for the dosage of Turpentine 5mg that was not administered in accordance to the doctor's orders. The Medication Tech in-serviced staff on following the physician orders as written when administering medication. The Medical Staff (RN and Med Tech) will perform weekly observations of medication administration passes to ensure staff administer medication in compliance of physician's orders. Globally, all RGH staff (Houses #1 - H#6) will be in-serviced on the administration of medication in compliance of physician's orders.	09/24/18 09/24/18 10/27/18 10/11/18
W 443	EVACUATION DRILLS CFR(s): 483.470(i)(1)(ii)	W 443		

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W 443	Continued From page 7 The facility must hold evacuation drills to ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features. This STANDARD is not met as evidenced by: Based on review of facility fire evacuation reports and interviews, the facility failed to assure all personnel on all shifts are trained to perform assigned tasks during emergency fire drill and are familiar with all fire drill procedures. The finding is: Review of the facility fire drill reports on 9/24/18 revealed 12 fire drill reports for all shifts of personnel from 9/18/17- 8//21/18 for all homes on the facility. The shifts of the exaction drills were reported as 7:00AM - 3:00PM for 1st shift, 3:00 PM-11:00PM for 2nd shift, and 11:00PM -7:00 AM for 3rd shift. Continued review of the annual evacuation reports on 9/25/18 from 09/18/17 to 8/21/18 revealed all drills were conducted by one consistent staff member only. Continued review of facility records revealed there has been no training for any other staff in the facility to learn how to be familiar with the conduct fire drills in the homes within the facility. Subsequent review of training records revealed staff have been trained to use fire extinguishers only, but have not been trained on how to operate the homes fire alarms or to notify the fire department or fire alarm company when drills are conducted. Interview with the one staff member on 9/25/18 who conducts all of the evacuation drills, revealed that he is the only staff member trained to perform the fire evacuation drills for all homes, for all shifts, each month. Continued interview with this staff member verified that he conducts	W 443	Policy and Procedure In-service will be performed with Emergency Management Coordinator and QIDPs to ensure fire drills are conducted per RGH policy and procedure guidelines. RGH Maintenance Personnel serve as alternate individuals for RGH to communicate w/Central Station (Fire Alarm System) to authorize testing of fire system and/or changes on the behalf of residential facilities fire alarm system. Facility personnel will continue to alert Central Station on behalf of false alarms with fire system Fire Drill training will be conducted during on boarding orientation with the facilities new hires. Each employee will be trained to operate the homes fire alarms and notify Central Station in the event of a fire /or/ when a drill is conducted. Competency test will be completed and added to the employment training file. During fire drills reporting, the Emergency Management Coordinator and/or Maintenance Personnel performing the drill will ensure that the residential staff that participated in the fire drill also sign the fire drill report.	09/25/18 11/01/18 09/25/18 09/25/18

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W 443	Continued From page 8 safety trainings for the facility and no other staff members have been trained or conducted fire evacuation drills for this annual review period of 9/2017 -9/2018 except for himself. Interview with the facility Qualified Intellectual Disabilities Professionals (QIDPs) on 9/25/18 confirmed that only one consistent staff member has been trained and performs all fire evacuation drills for the group homes on all shifts. Continued interview with the facility QIDPs on 9/25/18 verified that the facility was not aware that all staff are required to be trained to perform fire evacuation drills, nor was the facility aware that all staff must be familiar with the use of the facility's fire protection features such as the fire alarm and must be trained to perform fire evacuation drills, along with and any other safety features or procedures in the facility. Subsequent interview with the facility QIDPs confirmed only one staff member has been conducting all fire evacuation drills for this annual review period and no other staff has been trained to do so. Therefore the facility failed to assure all staff are familiar with and trained to conduct fire evacuations drills along with all safety procedures within the facility.	W 443		