PRINTED: 11/06/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	·····	(X3) DATE COMPI	
		34G113	B. WNG_			10/3	31/2018
	ROVIDER OR SUPPLIER N RIDGE GROUP HOME			STREET ADDRESS, CI 810 KING ARTHUR D GASTONIA, NC 28	RIVE		
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E 006	CFR(s): 483.475(a)(1 [(a) Emergency Plan. and maintain an emethat must be reviewed annually. The plan m (1) Be based on and facility-based and corresponding to the plan must be reviewed annually. The plan must be reviewed annually. The plan must be reviewed annually. The plan must be reviewed and corresponding to the plan must be a seen and include a document of the plan plan must be revented and include a document be revented and the plan be revented by the risk management of the plan be revented by the risk management of the plan be recorded and failures, natural disast that would affect the care. This STANDARD is Based on record revented and failed to develop the respondent based approach and failed facility-based strateging information. The find the plan between the	The [facility] must develop regency preparedness plan d, and updated at least ust do the following:] include a documented, mmunity-based risk an all-hazards approach.* §483.73(a)(1):] (1) Be based umented, facility-based and k assessment, utilizing an a, including missing residents. 3.475(a)(1):] (1) Be based on ented, facility-based and k assessment, utilizing an a, including missing clients. s for addressing emergency he risk assessment. 418.113(a)(2):] (2) Include sing emergency events assessment, including the consequences of power sters, and other emergencies hospice's ability to provide not met as evidenced by: view and interviews, the lop and maintain an lness (EP) plan to include a ed on an all-hazards to develop specific lies and specific client ding is:	E	Plea	C Black Mouse Received by: STORY	ntain WA	18 30 18
LABORATORY	1	SUPPLIER REPRESENTATIVE'S SIGNATUR	E .		TITLE &		(X6) DATE

Any deficiency statement ending with an asterisk (**Ydenotes 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.

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	COMPI	
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E 006	Continued From pag	ge 1	E	006			
	the facility's Adult R titled Emergency-Di was approved by th 12/1/15 and include however, no informaresiding in the group to the geographic local included. Interviews conducted with the qualified in professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional and infinity 10/31/18 with the acceptance of the professional acc	on 10/30/18 of Section 2.01 of esidential Services Manual, saster Plan, revealed the plan e Executive Committee on d general information for EP; ation specific to clients o home or information relative ecation of the group home was ed on 10/30/18 and 10/31/18 tellectual disabilities rerviews conducted on dministrator revealed the d not been updated since			Please See Affachments	\$	
E 013	12/1/18 and specific relative to the geog client-specific inform persons unfamiliar needed assistance.	c information was not included raphic location of the home or nation that would enable with the clients to provide the	E	013			12(30)65
	develop and impler policies and proced plan set forth in parassessment at para and the communicathis section. The policies are the policies and the communication of the policies and the policies are the policies and procedure are the policies are th	ncedures. [Facilities] must ment emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually.					7
	Facilities:	ements for PACE and ESRD 0.84(b):] Policies and					
		ACE organization must					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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E 013	develop and implem policies and proceduplan set forth in para assessment at paragand the communicat this section. The pol address manageme emergencies, includ equipment, power, cemergencies; and not threaten the health of staff, or the public. The must be reviewed an assessment at para and the communicat this section. The porreviewed and updat emergencies include equipment or power emergencies, water natural disasters like geographic area. This STANDARD is Based on review of interviews, the facility procedures were deconthe facility's emerglan. The finding is Review conducted of the facility's Adult R titled Emergency-D	ent emergency preparedness ares, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of icies and procedures must at of medical and nonmedical ing, but not limited to: Fire; or water failure; care-related atural disasters likely to or safety of the participants, the policies and procedures and updated at least annually. Is at §494.62(b):] Policies and allysis facility must develop and crypreparedness policies and procedures and on the emergency plan set and on the emergency plan set and on the emergency plan set and procedures must be end at least annually. These end at least annually interruption, and end to occur in the facility's and met as evidenced by: if facility documents and staff ty failed to ensure policies and eveloped and updated based or gency preparedness (EP)	E	Please See Attachm	ints		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE S COMPL	
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E 029	emergency prepared did not include currer regarding the emerge and the communication of the c	general information for ness; however, the EP plan int policies and procedures ency plan, risk assessment on plan. d on 10/30/18 and 10/31/18 ellectual disabilities administrator on 10/31/18 did not include current eres relative to the facility's explan.		013	Please See Attachments		R[30]68

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` `	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G113	B. WING_			10/3	1/2018
	ROVIDER OR SUPPLIER N RIDGE GROUP HOME			810 H	EET ADDRESS, CITY, STATE, ZIP CODE KING ARTHUR DRIVE STONIA, NC 28054	,	
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E 039	disabilities profession revealed the current updated since 12/1/1 current information remeans of communical emergency/disasters: EP Testing Requirem CFR(s): 483.475(d)(3) (2) Testing. The [faci RNHCIs and OPOs] test the emergency profession of the following: *[For LTC Facilities at The LTC facility must the emergency plan unannounced staff dorocedures. The LTC following:] (i) Participate in a furth community-based or exercise is not acceptable for the actual natural or material procedures.	with the qualified intellectual nal and administrator EP plan has not been 5, and does not contain elative to primary or alternate ation during an situation. In the elast annually. The NHCIs and OPOs] must do at §483.73(d):] (2) Testing. It conduct exercises to test at least annually, including rills using the emergency of facility must do all of the lessible, an individual, [facility] experiences an in-made emergency plan, the		039	Please See Affachment	5	12/8
	full-scale exercise for the actual event. (ii) Conduct an addit include, but is not lir	r individual, facility-based or 1 year following the onset of cional exercise that may nited to the following: scale exercise that is					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLÉTION DATE
E 039	(B) A tabletop exe discussion led by a for clinically-relevant emore problem statement prepared questions of emergency plan. (iii) Analyze the [facilimaintain documental exercises, and emer [facility's] emergency *[For RNHCIs at §40 §486.360] (d)(2) Test must conduct exercise plan. The [RNHCI are following: (i) Conduct a paper least annually. A table discussion led by a folinically relevant emore problem statement prepared questions emergency plan. (ii) Analyze the [RN to and maintain document exercises, and emer [RNHCI's and OPO's needed. This STANDARD is Based on review of interviews, the facility facility/community-butest the current emergian were conducted to the facility's Adult Review conducted of the facility's A	individual, facility-based. rcise that includes a group acilitator, using a narrated, nergency scenario, and a set ts, directed messages, or designed to challenge an lity's] response to and tion of all drills, tabletop gency events, and revise the v plan, as needed. 3.748 and OPOs at ting. The [RNHCl and OPO] ses to test the emergency and OPO] must do the -based, tabletop exercise at letop exercise is a group facilitator, using a narrated, nergency scenario, and a set ats, directed messages, or designed to challenge an HCl's and OPO's] response umentation of all tabletop gency events, and revise the s] emergency plan, as not met as evidenced by: facility documents and staff ty failed to ensure ased or tabletop exercises to rgency preparedness (EP)	E	Please See Attachm	ents

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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E 039	12/1/15 and included emergency prepared did not include a full-individual facility-base exercise to test their Interviews conducted intellectual disabilities administrator verified conducted a full-scale exercise or a tableto effectiveness of their PROTECTION OF CCFR(s): 483.420(a)() The facility must ensigned the survey of the facility failed to assure a sampled client (#2). Throughout observations of client #2's window covering. Far visible tinted film of client #2's bedroom observations of client revealed a clear, unhome located next of linterviews conducted.	Executive Committee on a general information for liness; however, the EP plan iscale community-based or sed exercise or tabletop emergency plan. If 10/31/18 with the qualified is professional and the id the facility/community-based preserved by exercise to test the recurrent emergency plan. In IENTS RIGHTS The finding is: In the group home eriod 10/30/18 to 10/31/18 bedroom window to have no urther observations revealed on a small, lower portion of window pane. Continued in #2's bedroom window obstructed side view of the	E 03	Please See Attachment	ち	15/34/4

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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W 227	client #2 has a behave bedroom window covering has week. Continued into tore off his bedroom window covering has week. Continued into tore off his bedroom window on 10/31/18 of support plan (BSP) dobjective to "reduce of behaviors during white displayed to no more for 6 consecutive more revealed the following aggression, property noncompliance/resist behavior, and elopent linterview with the quiprofessional (QIDP) of client #2 should have bedroom window(s) to INDIVIDUAL PROGECER(s): 483.440(c)(4). The individual program objectives necessary as identified by the crequired by paragraph. This STANDARD is The facility failed to program plan (IPP) foincluded objective transports.	rior of tearing down his berings and his bedroom been off for about one erviews revealed client #2 window covering last week. of client #2's behavior ated 5/26/18 revealed an episodes of disruptive ch a target behavior is than 6 episodes per month on this." Continued review g target behaviors: destruction/misuse, tance, self injurious ment. alified intellectual disabilities werified all clients including a window coverings on their to ensure privacy. RAM PLAN (4) am plan states the specific or to meet the client's needs, comprehensive assessment of (c)(3) of this section. not met as evidenced by: assure the individual or 1 of 3 sampled clients (#2) aining to meet the client's ced by observation, interview	W 1	Please See Affichment	5	15/30/18	

PRINTED: 11/06/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING ___ 34G113 B. WING_ 10/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

810 KING ARTHUR DRIVE

MOUNTAI	N RIDGE GROUP HOME	GASTONIA, NC 28054				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ix	PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE COMPI		
W 227	Continued From page 8 Throughout observations in the group home during the survey period 10/30/18 to 10/31/18 revealed client #2's bedroom window to have no window covering. Further observations revealed a visible tinted film on a small, lower portion of client #2's bedroom window pane. Continued observations of client #2's bedroom window revealed a clear, unobstructed side view of the home located next door. Interviews conducted with staff (3) throughout the survey period 10/30/18 to 10/31/18 revealed client #2 has a behavior of tearing down his bedroom window coverings and his bedroom window covering has been off for about one week. Continued interviews revealed client #2 tore off his bedroom window covering last week. Review on 10/31/18 of client #2's IPP dated 2/26/18 revealed the following programs: purchase an item in the community, exercise social distance, knock before entering bedroom or bathroom, engage in home/community/physical/medication activities, prepare a side item, brush his teeth, complete chores, wash hands, expand social skills/interests, and use picture cards to communicate when outside the home. Review on 10/31/18 of client #2's behavior support plan (BSP) dated 5/26/18 revealed an objective to "reduce episodes of disruptive behaviors during which a target behavior is displayed to no more than 6 episodes per month for 6 consecutive months." Continued review revealed the following target behaviors: aggression, property destruction/misuse, noncompliance/resistance, self injurious behavior, and elopement.	W	22	Please See Affachments		

	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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W 227	professional (QIDP) retear down any of the Additional interview with QIDP verified clie objective training to a tearing down window DRUG ADMINISTRA CFR(s): 483.460(k)(1). The system for drug that all drugs are admitted that all drugs are admitted that all drugs are administered in comporders failed for 1 of observed as evidence and review of records. Observations in the gadministration on 10/client #1 received Fe Eliquis, Escitalopramand Vitamin D. Review on 10/31/18 dated 9/1/18 to 9/30/also receive "Chlorhet toothbrush and use to (Do not swish or swall interview on 10/31/18 revealed client #1 received with the control of the	alified intellectual disabilities revealed client #2 will also home's window coverings. with the home manager and ant #2 currently has no address his behavior of coverings. TION) administration must assure ministered in compliance with s. not met as evidenced by: for ensuring drugs were oliance with physician's 3 sampled clients (#1) ed by observations, interview		368	Please See Attachment		12/34/66

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE S COMPLI	
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W 368	Gluc 0.12% Sol at 6 any prescribed topical Review on 10/31/18 physician's orders ar manager and the quaprofessional (QIDP) receive his Chlorhex prescribed. DRUG STORAGE A CFR(s): 483.460(l)(2) Only authorized perskeys to the drug storal failed to assure only access to the keys to finding is: Observations condurevealed staff retrieves storage closet from kitchen and opened area. Staff was there to the drug storage at the closet. Further observealed the house the outside door knowstorage area to review at the controlled drug storage area to review at the controlled drug storage area at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage area at the review at the controlled drug storage at the cont	ceives his Chlorhexidine AM every morning along with als. of the 9/1/18 to 9/30/18 nd verified by the home alified intellectual disabilities revealed client #1 should idine Gluc 0.12% Soln as ND RECORDKEEPING (2)	W		a se fachment	<u>-</u> s	15/34/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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W 383	drawer. Observation conduct 10/31/18 at 7:15 AM keys to the drug adm unsecured drawer in door to the drug adm then noted to perform administration procesat which time the key unsecured drawer in remained throughout Observation of the cowhere the keys were sets of keys and varial Interview conducted manager, conducted verified the keys were kitchen drawer where further revealed the	ed on the morning of revealed staff retrieved the hinistration area from the the kitchen and opened the hinistration area. Staff was in the morning drug as from 7:15 AM to 7:55 AM as were returned to the the kitchen where they at survey observations, contents of the kitchen drawer a located revealed several ious household items. with the group home on 10/31/18 at 9:00 AM are currently being kept in the in not in use. This interview keys to the drug storage area apt on the person of the staff	W 383	Please Sce Attachmen	ろ	

Mountain Ridge Plan of Corrections

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.

Mountain Ridge will develop and maintain an emergency preparedness plan including an all hazardous approach risk assessment. This plan will be specifically community and facility based upon the risk assessment.

An Emergency Preparation book will be developed for the facility in which facility/geographic and individual specified information will be maintained. All staff will be trained on the Emergency Preparation book. The Program Director will ensure that the initial training is conducted and continues for any new staff. Once initially trained, all staff will be trained on Emergency Preparation book annually along with annual emergency preparation.

E013: Development of EP Policies and Procedures CFR(s): 483.475(b)

(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 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. *Additional Requirements for PACE and ESRD Facilities:

*[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility geographic area.

Lutheran Services Carolinas (Lutheran Family Services in the Carolinas) approved the updated Emergency-Disaster Plan Policy and Procedure on 7-1-18. An addendum will be added to the current Policy and Procedure to include emergency planning using an all hazard approach. This includes risk assessment, communication plan, training program, and policy & procedures. The policy and procedure plan will be reviewed and updated at least once annually. Quality Management will ensure that this plan is reviewed and updated annually. The Adult Residential Service Director and Program Director, QP will ensure that staff receive annual training on the emergency disaster Policy and Procedure.

E 029 Development of Communication Plan CFR(s): 483.475(c)

(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.

Lutheran Services Carolinas (Lutheran Family Services in the Carolinas) approved the updated Emergency-Disaster Plan Policy and Procedure on 7-1-18. An addendum will be added to the current Policy and Procedure to include emergency planning using an all hazard approach. This includes risk assessment, communication plan, training program, and policy & procedures. The Communication plan will include names and contacts of all entities connected to the facility to include staff, physicians, volunteers and any federal, state, and local emergency management agencies. This plan will include guardian's signatures to release general and medical information. The Communication Plan will be reviewed and updated annually. The Adult Residential Director and Program Director, QP will ensure staff receive annual training on the communication plan.

E 039 EP Testing Requirements

CFR(s): 483.475(d)(2)

(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A)A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.*[For RNHCls at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCl and OPO] must conduct exercises to test the emergency plan. The [RNHCl and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

Lutheran Services Carolinas (Lutheran Family Services in the Carolinas) approved the updated Emergency-Disaster Plan Policy and Procedure on 7-1-18. An addendum will be added to the current Policy and Procedure to include emergency planning using an all hazard approach. This includes risk assessment, communication plan, training program, and policy & procedures. Mountain Ridge will participate in a community or facility simulated disaster drill annually, unless an actual natural or man-made emergency occurs causing activation of the emergency plan. Also annually, a facilitator will lead a table top exercise using a clinically relevant emergency scenario. These trainings will be documented and all participants will sign an in service/training sheet. The Adult Residential Director and Program Director, QP will ensure staff receive annual training on the testing requirements.

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.

Mountain Ridge will ensure the rights of all clients to include ensuring privacy during treatment and care of personal needs. All clients will have window covering on their windows at all times. An in service will be completed with staff to understand that window covering needs to be on windows at all times. If it is deemed that a client needs darkening film on window to ensure window covering at all times, then the darkening film will be put on the window. However, a blind will be replaced on the window when needed. During facility checks, if dark film is placed on window it will be added to the check list to ensure it stays adhesive to the window. The Program Manager will ensure window coverage is on windows at all times.

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.

Mountain Ridge will ensure specific objectives necessary to meet client's needs are addressed as a need is identified. During observation, client number 2 has an objective to "reduce episodes of disruptive behaviors to no more than 6 episodes per month for 6 consecutive months. Therefore, to address tearing blinds off window an objective will be implemented to assist client 2 leaving blind on window. Also a form will be implemented for each client to document and discuss any patterns of behavior or tasks they are needing more assistance with completing. This form will be completed during monthly staff meetings and IHP meetings. If a client need is identified an objective will be implemented to address the area of need. The Program Director, QP will complete the client forms during the meetings and complete observations.

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.

Mountain Ridge will ensure that all drugs are administered in compliance physician's orders. Mountain Ridge will complete an in service on the medication procedure that all medication is to be administered as written on physician orders. The in service will emphasize that all medications include topical, shampoos, mouth rinse etc. The Program Director, QP will monitor for compliance

W 383 DRUG STORAGE AND RECORDKEEPING

CFR(s): 483.460(l)(2)

Only authorized persons may have access to the keys to the drug storage area.

Mountain Ridge will ensure that only authorized persons will have access to the keys to the drug storage area. A combination locked box will be purchased and placed in side of a filing cabinet for keys to be placed in when not in use. This box will have all keys locked in it. The key to the box will be hid in a secure place and only authorized staff will know where it is located. When staff are present at the group home, the medication keys will be kept on the staff assigned to administer medications during the shift at all times. The medication closet and drawer keys will be on a wrist or neck key chain. The Program Director, QP will monitor this procedure to ensure consistent implementation.

All of the above plan of corrections will be implemented by December 30th, 2018