PRINTED: 11/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE S	
		34G204	B. WING			11/0	)8/2018
NAME OF PE	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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E 004	CFR(s): 483.475(a)  [The [facility] must consider of Federal, State and long prepared ness required develop establish an emergency prepared requirements of this states and states are states as a state of the states are states are states are states as a state of the states are stat	ements. The [facility] must d maintain a comprehensive liness program that meets the section.]  82.15 and CAHs at ospital or CAH] must comply ederal, State, and local liness requirements. The list develop and maintain a regency preparedness the requirements of this all-hazards approach.  Daredness program must mited to, the following  The [facility] must develop ergency preparedness plan led], and updated at least less at §494.62(a):] Emergency cillity must develop and ncy preparedness plan that, and updated at least less and review of records, the ion failed to develop and	E	004	Ptase sec attach went DHSR - Mer NOV 21 Lic. & Cert	2018	
		D/SI IDDI IED DEDDESENTATIVE'S SIGNATI I			TITLE		(VE) DATE )

Any defisiency statement ending with an adjerisk (\*) 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.

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION . ,	(X3) DATE SURVEY COMPLETED	
		34G204	B. WING		11/08/2018	
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E 004	Continued From pag	e 1	E	004		
	revealed an undated general information f however, the EPP di and procedures rega risk assessment and	n 11/7/18 of facility records disaster plan and included for emergency preparedness; d not include current policies arding the emergency plan, the communication plan.				
E 006	revealed the group he developed well before she was unaware of regulatory requirement interview revealed standard policies comprehensive eme communication plan assessment, using a Subsequent intervier administrator and the develop a comprehenecessary component the health and safet	ents by CMS. Continued the did not develop and procedures based on a figency preparedness plan, or conduct a risk an all hazards approach. w on 11/8/18 with the facility e QIDP verified they will ensive EPP to include the		Please see attachment		
	CFR(s): 483.475(a)(  [(a) Emergency Plar and maintain an em that must be review annually. The plan r  (1) Be based on and facility-based and co assessment, utilizin  *[For LTC facilities a on and include a do community-based ri			Ptaso sto athinnent	17 M	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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E 006	Continued From page	e 2	E	006			
	and include a docum community-based ris all-hazards approach (2) Include strategie events identified by t * [For Hospices at §4 strategies for addres identified by the risk management of the failures, natural disast that would affect the care, This STANDARD is Based on record revision and failed facility failed to deve emergency prepared risk assessment bas approach and failed facility-based strateginformation. The find The facility did not he comprehensive EPP Review conducted of documentation reveal and included general however, no informates included.  Interviews conducted included.	and the state of t			Please see attachment		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
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E 006	EPP had not been up and specific informat regarding the geogra client-specific information persons unfamiliar was needed assistance.	ntiated the facility's current odated since last ýear or so		013		
	(b) Policies and proc develop and impleme policies and procedu plan set forth in para assessment at parag and the communicati this section. The poli reviewed and update	edures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be		House sca attachment	-	17/15
	develop and implement policies and procedure plan set forth in para assessment at paragand the communicat this section. The policies management emergencies, including equipment, power, of emergencies; and not threaten the health costaff, or the public. T	B4(b):] Policies and DE organization must ent emergency preparedness res, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of cies and procedures must nt of medical and nonmedical ng, but not limited to: Fire; r water failure; care-related atural disasters likely to or safety of the participants, the policies and procedures and updated at least annually.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	riple construction		TE SURVEY MPLETED
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E 013	procedures. The dialy implement emergency procedures, based or forth in paragraph (a) assessment at paragrand the communicati this section. The politic reviewed and update emergencies include equipment or power emergencies, water anatural disasters like geographic area. This STANDARD is Based on review of interviews, the facility procedures were devon the facility's emer (EPP). The finding The facility did not have relative policies and Review conducted or revealed an undated general information of however, the EPP di and procedures regarisk assessment and Interviews conducted intellectual disabilitie administrator on 11/8 assessment and 11/8 administrator on 11/8 administrator on 11/8 assessment and 11/8 administrator on 11/8 administrator o	at §494.62(b):] Policies and ysis facility must develop and by preparedness policies and in the emergency plan set of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be did at least annually. These but are not limited to, fire, failures, care-related supply interruption, and ly to occur in the facility's not met as evidenced by: facility documents and staff of failed to ensure policies and delegancy preparedness plan is:	E	PEUSC SCO	·	
E 029	the the facility's eme	rgency response plan.	E	029 HOSC 8(1) (H	tachwent	

NAME OF PROVIDER OR SUPPLIER    STREET ADDRESS, CITY, STATE, ZIP CODE   188 MARTINDALE RD   WINSTON SAILEM, NC 27107   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   DPREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   DPREFIX   TAG   PROVIDERS PLAN OF CORRECTION   CROSS-REFERENCED TO THE APPROPRIATE   CR	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
WILSON SMITH COTTAGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC (DEMTIFYING INFORMATION))  E 029  Continued From page 5  (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.  This STANDARD is not met as evidenced by: Based on review of facility documents and staff interviews, the facility falled to develop specific policies and procedures to address emergency preparedness including a specific communication plan that complies with federal, state and local laws and is updated at least annually. The finding is:  The facility did not have a comprehensive EPP relative to a communication plan.  Review conducted on 11/7/18 of the facility records revealed an undated disaster plan and included general information for emergency preparedness, however, the emergency preparedness, however, the emergency preparedness plan (EPP) did not include current policies and procedures regarding communication means (primary or alternate) during any emergency/disaster situation.  Interviews conducted with the qualified intellectual			34G204	B, WING		<u> </u>	11/0	8/2018
WINSTON SALEM, NC 27107    PROPRIET   SUMMARY STATEMENT OF DEFICIENCIES   PROPRIET   PRO								
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(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.  This STANDARD is not met as evidenced by: Based on review of facility documents and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness including a specific communication plan that complies with federal, state and local laws and is updated at least annually. The finding is:  The facility did not have a comprehensive EPP relative to a communication plan.  Review conducted on 11/7/18 of the facility records revealed an undated disaster plan and included general information for emergency preparedness; however, the emergency preparedness; however, the emergency preparedness plan (EPP) did not include current policies and procedures regarding communication means (primary or alternate) during any emergency/disaster situation.  Interviews conducted with the qualified intellectual	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
the current EPP has not been updated since last year or so and does not contain current information pertaining to primary or alternate means of communication during an emergency/disaster situation.  E 036 EP Training and Testing CFR(s): 483.475(d)  (d) Training and testing. The [facility] must		(c) The [facility] must emergency prepared that complies with Fe and must be reviewed annually.  This STANDARD is Based on review of interviews, the facility policies and procedure preparedness included plan that complies we laws and is updated is:  The facility did not have relative to a communative to a communicative preparedness; howe preparedness plan (policies and proceduring any emergent linterviews conducted disabilities profession the current EPP has year or so and does information pertaining means of communicative mergency/disaster EP Training and Test CFR(s): 483.475(d)	develop and maintain an ness communication plan ideral, State and local laws d and updated at least mot met as evidenced by: facility documents and staff of failed to develop specific res to address emergency ing a specific communication with federal, state and local at least annually. The finding ave a comprehensive EPP dication plan.  In 11/7/18 of the facility undated disaster plan and formation for emergency in the emergenc			Place see attachment		1/1/19

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E 036	develop and maintain preparedness trainin based on the emerging paragraph (a) (1) of the procedures at paragraph (a) (1) of the procedures at paragraph (a) (1) of the procedures at paragraph (a) testing. The ICF/IID at §48 testing. The ICF/IID an emergency preparagraph (b) of this section, and the comparagraph (c) of this testing program multipleast annually. The requirements for every \$483.470(h).  *[For ESRD Facilities testing, and orientation program emergency plan sets section, risk assess this section, policies (b) of this section, aparagraph (c) of this and orientation program paragraph (c) of this and orientation program testing program testing testing paragraph (c) of this section, aparagraph (c) of this and orientation program testing testing testing paragraph (c) of this section, aparagraph (c) of this section, aparagraph (c) of this standorientation program that is STANDARD is standard testing the section or the	an an emergency g and testing program that is ency plan set forth in section, risk assessment at his section, policies and raph (b) of this section, and plan at paragraph (c) of this g and testing program must dated at least annually.  33.475(d):] Training and must develop and maintain aredness training and testing ed on the emergency plan set a) of this section, risk graph (a)(1) of this section, ures at paragraph (b) of this munication plan at a section. The training and set be reviewed and updated at ICF/IID must meet the accuation drills and training at  as at §494.62(d):] Training, tion. The dialysis facility must in an emergency ng, testing and patient that is based on the at forth in paragraph (a) of this ament at paragraph (a) of this ament at paragraph (a) (1) of and procedures at paragraph and the communication plan at as section. The training, testing gram must be reviewed and nually. In an energan evidenced by: It facility documents and staff	. E	036	Plase see Machinant		1/1/19

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E 036	facility/community-batest the current emer (EPP) were conducted. The facility did not hatabletop and full-sca. Review conducted or revealed an undated general information however, the EPP pl community-based or exercise or tabletop emergency plan. No facility training and twas found or provide Interviews conducted intellectual disabilitie administrator on 11/ not conducted a full-facility/community-b	ased or tabletop exercises to regency preparedness plan ed. The finding is:  ave documented annual le EPP exercises.  In 11/7/18 of facility records disaster plan and included for emergency preparedness; lan did not include a full-scale individual facility-based exercise to test their written documentation of esting exercises for the EPP ed.  In 11/7/18 with the qualified es professional and the facility 8/18 verified the facility had	E	036	Hease see attachment		

#### Wilson Smith Cottage Plan of Corrections

E004: Develop EP Plan, Review and Update Annually

CFR(s): 483.475(a)[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.]\* [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. \*[For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least

Wilson Smith Cottage 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.

E006: Plan Based on All Hazards Risk Assessment

CFR(s): 483.475(a)(1)-(2)

annually.

[(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.

Wilson Smith Cottage 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's 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.

EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. \*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency-plan-set-forth-in-paragraph-(a)-of-this-section, risk-assessment-at-paragraph-(a)(1)-of-this-section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). \*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program 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. Wilson Smith Cottage 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.

All of the above corrections will be implemented by 1-7-2019