STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD WINSTON SALEM, NC 27107

(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 004	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 annually. This STANDARD is not met as evidenced by: Based on interviews and review of records, the facility's administration failed to develop and maintain a comprehensive emergency preparedness plan (EPP). The finding is: The facility did not have a comprehensive EPP.	E 004	Please see attachment DHSR - Mental Health NOV 21 2018 Lic. & Cert. Section	1/1/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Program Director QP (X6) DATE: 11/19/18

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 004	Continued From page 1 Review conducted on 11/7/18 of facility records revealed an undated disaster plan and included general information for emergency preparedness; however, the EPP did not include current policies and procedures regarding the emergency plan, risk assessment and the communication plan. Interview conducted on 11/7/18 with the QIDP revealed the group home's current EPP was developed well before she arrived on 3/2018 and she was unaware of the EPP mandatory regulatory requirements by CMS. Continued interview revealed she did not develop emergency policies and procedures based on a comprehensive emergency preparedness plan, communication plan, or conduct a risk assessment, using an all hazards approach. Subsequent interview on 11/8/18 with the facility administrator and the QIDP verified they will develop a comprehensive EPP to include the necessary components to be compliant to ensure the health and safety of clients.	E 004	Please see attachment	
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.	E 006	Please see attachment	1/1/19

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E 006	Continued From page 2 *[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 record review and interviews, the facility failed to develop and maintain an emergency preparedness plan (EPP) to include a risk assessment based on an all-hazards approach and failed to develop specific facility-based strategies and specific client information. The finding is: The facility did not have an updated comprehensive EPP. Review conducted on 11/7/18 of facility documentation revealed an undated disaster plan and included general information for EPP; however, no information specific to clients residing in the group home or information relative to the geographic location of the group home was included. Interviews conducted on 11/7/18 with the qualified intellectual disabilities professional and an interview conducted on 11/8/18 with the facility	E 006	Please see attachment	

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E 006	Continued From page 3 administrator substantiated the facility's current EPP had not been updated since last year or so and specific information was not included regarding the geographic location of the home or client-specific information that would enable persons unfamiliar with the clients to provide the needed assistance.	E 006		
E 013	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 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. *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.	E 013	Please see attachment	1/7/19

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E 013	Continued From page 4 *[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. This STANDARD is not met as evidenced by: Based on review of facility documents and staff interviews, the facility failed to ensure policies and procedures were developed and updated based on the facility's emergency preparedness plan (EPP). The finding is: The facility did not have a comprehensive EPP relative policies and procedures. Review conducted on 11/7/18 of facility records revealed an undated disaster plan and included general information for emergency preparedness; however, the EPP did not include current policies and procedures regarding the emergency plan, risk assessment and the communication plan. Interviews conducted on 11/7/18 with the qualified intellectual disabilities professional and the facility administrator on 11/8/18 verified the EPP did not include current policies and procedures regarding the the facility's emergency response plan.	E 013	Please see attachment	
E 029	Development of Communication Plan CFR(s): 483.475(c)	E 029	Please see attachment	

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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 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 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 disabilities professional and administrator verified 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 029	Please see attachment	11/7/19
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must	E 036		

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E 036	Continued From page 6 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. This STANDARD is not met as evidenced by: Based on review of facility documents and staff interviews, the facility failed to ensure	E 036	Please see attachment	1/1/19

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E 036	Continued From page 7 facility/community-based or tabletop exercises to test the current emergency preparedness plan (EPP) were conducted. The finding is: The facility did not have documented annual tabletop and full-scale EPP exercises. Review conducted on 11/7/18 of facility records revealed an undated disaster plan and included general information for emergency preparedness; however, the EPP plan did not include a full-scale community-based or individual facility-based exercise or tabletop exercise to test their emergency plan. No written documentation of facility training and testing exercises for the EPP was found or provided. Interviews conducted 11/7/18 with the qualified intellectual disabilities professional and the facility administrator on 11/8/18 verified the facility had not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 036	Please 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 annually.

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)
[(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