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

PRINTED: 11/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION (X2) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION		(X2) MULT		(X3) DATE SURVEY COMPLETED				
WAN LIMIT OF	34G207		B. WING		·	11/20/2018			
NAME OF PROVIDER OR SUPPLIER MYRTLEWOOD GROUP HOME				17	REET ADDRESS, CITY, STATE, ZIP CODE 5 MYRTLEWOOD DRIVE OUNT GILEAD, NC 27306				
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E TE	(X5) COMPLETION DATE		
E 018	CFR(s): 483.475(b)(a [(b) Policies and prodevelop and implementation of the communication of	cedures. The [facilities] must ent emergency preparedness tres, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of icies and procedures must be ed at least annually.] At a es and procedures must g:]	E	018	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
	(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of				DEC - 3 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.

Facility ID: 922263

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

NAME OF PROVIDER OR SUPPLIER NYRTLEWOOD GROUP HOME SUMMARY STATEMANT OF DEPOLIENCE TO SHAPPLIER NYRTLEWOOD GROUP HOME SUMMARY STATEMANT OF DEPOLIENCES GROUP HOME MOUNT GILEAD, NC 27306 GRAD DEPOLIENCY MUST SEP PRECEDED BY TULL RESOLUTION OF MOUNT GILEAD, NC 27306 COMPLIANCY OR US DESTREYMEN INFORMATION PRECEDED BY TULL RESOLUTION AS OLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 018 Continued From page 1 assistance. (V) A system to track the location of hospice employees' on-duty and afheliered patients in the hospica's care during an emergency. If the on-duty employees or shellsed patients are relocated during the emergency, the hospica must document the specific name and location of the receiving facility or other location. *[For CMHCs at §486.320(b):] Policies and procedures. (2) Safe evacuasition from the CMHC, which includes consideration of care and treatment needs of evacuases; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For CPCs at § 488.380(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentially of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.82(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on review of the facility's "Crisis information" and "Risk Management" emergency preparedness (EP) plan notebooks and interview, the facility as EP plan's policies and procedures. The finding is: The finding is:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
MYRTLEWOOD GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) PREFIX TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) PREFIX TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) PREFIX TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) PREFIX TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) PREFIX TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) PREFIX TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCY PROPRIES AND OF CORRECTION SHOULD BE CONFIDENCY TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) PROPRIES AND OF CORRECTION SHOULD BE CONFIDENCY TAG CONTINUED TO PROPRIES AND OF CONFIDENCY TO POD at § 486.360((0):) Policies and procedures. (2) A system of medical dorumentation that preserves potential and actual donor information, and secures and maintains the availability of records. "[For CPOs at § 486.360((c):) Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities; and needs of the patients. This STANDARD is not met as evidenced by: Based on review of the facility's "Crisis Information" and "Risk Management" emergency preparedness (EP) plan notebooks and interview, the facility falled to develop a tracking system to document the locations of clients and staff as part of the facility's EP plan's policies and procedures. The finding is: The finding is:		34G207			<u> </u>		11/20/2018			
PREFIX TAG REGULATORY OR LSC DENTIFYING INFORMATION) E 018 Continued From page 1 assistance. (V) A system to track the location of hospice simployees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency between the receiving facility or other location. *[For CMHCs at \$485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacues; staff responsibilities; transportation; identification of evacuation forcedures. (2) A system of medical documentation with external sources of assistance. *[For OPOs at § 486.390(b):] Policies and procedures. (2) A system of medical documentation into the preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.82(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes steff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on review of the facility's "Crisis Information" and "Risk Management" emergency preparedness (EP) plan notebooks and interview, the facility failed to develop a tracking system to document the locations of clients and staff as part of the facility's EP plan's policies and procedures. The finding is:					175	5 MYRTLEWOOD DRIVE				
assistance. (y) A system to track the location of hospice employees' on-duty and shelfered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuese; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentially of procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on review of the facility's "Crisis Information" and "Risk Management" emergency preparedness (EP) plan notebooks and interview, the facility falled to develop a tracking system to document the locations of clients and staff as part of the facility's EP plant's policies and procedures. The finding is:	PREFIX	/FACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION		
Poview on 11/19/18 and 11/20/18 of the facility's	E 018	assistance. (v) A system to track employees' on-duty hospice's care during on-duty employees relocated during the must document the the receiving facility *[For CMHCs at §48 procedures. (2) Safe which includes constreatment needs of responsibilities; tranevacuation location means of communicassistance. *[For OPOs at § 48 procedures. (2) As documentation that donor information, potential and actual secures and maintal facility, which incluenceds of the patien This STANDARD is Based on review of Information" and "Foreparedness (EP) the facility failed to document the location of the facility's EP The finding is:	at the location of hospice and sheltered patients in the gran emergency. If the or sheltered patients are emergency, the hospice specific name and location of or other location. 35.920(b):] Policies and evacuation from the CMHC, sideration of care and evacuees; staff asportation; identification of (s); and primary and alternate cation with external sources of (s); and primary and alternate cation with external sources of (s); and primary and alternate cation with external sources of (s); and primary and alternate cation with external sources of (s); and primary and alternate cation with external sources of (s); and primary and alternate cation with external sources of (s); and primary and alternate cation with external sources of (s); and preserves potential and actual preserves potential and actual preserves potential and actual preserves potential and actual contects confidentiality of donor information, and sins the availability of records. 4.62(b):] Policies and set evacuation from the dialysis des staff responsibilities, and its. s not met as evidenced by: of the facility's "Crisis Risk Management" emergency plan notebooks and interview, develop a tracking system to clions of clients and staff as part plan's policies and procedures.	E	018					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G207	B. WNG			11/2	20/2018
	NAME OF PROVIDER OR SUPPLIER MYRTLEWOOD GROUP HOME			17	REET ADDRESS, CITY, STATE, ZIP CODE 5 MYRTLEWOOD DRIVE OUNT GILEAD, NC 27308		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROVIDENCY)			(X5) COMPLETION DATE
E 018	(specific client inform Management" (generand substantiated by intellectual disabilities revealed no tracking locations of clients are emergency. Continu verified they will deve to track clients and semergency and as procompliant with regula Arrangement with Ot CFR(s): 483.475(b)(incompliant with incompliant	ation) and "Risk alized facility information) interview with the qualified is professional (QIDP) system to document the nd staff in the event of an ed interview with the QIDP elop a documentation system taff in the event of an eart of the EP plan to be ations. her Facilities The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, ion plan at paragraph (c) of cies and procedures must be ed at least annually. At a s and procedures must g:] 18.113(b), PRFTs at als at §482.15(b), and LTC (b):] Policies and procedures. opment of arrangements with other providers to receive of limitations or cessation of in the continuity of services		018	E025 By 1-19-19, the facility will obtain documentation of the arrangements an agreements with other facilities to recollents in the event the facility is unabcare for clients during an emergency. QP/RM will train all staff on agreement with facility. QP will monitor quarter	eive le to The nts	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , ,	IPLE CONSTRUCT		COMPLETED		
		34G207	B. WING_				11/20/2018	
NAME OF PROVIDER OR SUPPLIER MYRTLEWOOD GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP GODE 175 MYRTLEWOOD DRIVE MOUNT GILEAD, NC 27306				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR EACH CORRECTIVE ACTION SI OSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 025	development of arr [facilities] [or] other in the event of limit operations to main to facility patients. *[For RNHCIs at §- procedures. (7) Th arrangements with providers to receiv limitations or cess the continuity of no patients. This STANDARD Based on review of Information" and "I preparedness (EP the facility failed to arrangements and facilities to receive is unable to care for The finding is: Review on 11/19/1 EP plan notebooks (specific client info Management" (ge and substantiated intellectual disabili revealed the facility of the arrangement facility has with ot evacuation. Conti- verified they will d arrangements and	dures. (7) [or (6), (8)] The rangements with other reproviders to receive patients rations or cessation of tain the continuity of services 403.748(b):] Policies and e development of a other RNHCIs and other e patients in the event of ation of operations to maintain on-medical services to RNHCI is not met as evidenced by: of the facility's "Crisis Risk Management" emergency plan notebooks and interview, or develop documentation of the for any agreements with other eclients in the event the facility or clients during an emergency. 18 and 11/20/18 of the facility's estitled "Crisis Information" or clients during an emergency. 18 and 11/20/18 of the facility's estitled "Crisis Information" or clients during an emergency. 19 to the facility information of the facilities professional (QIDP), by did not have documentation and the facilities in the event of an inued interview with the QIDP evelop documentation of any agreements they have with the event of an evacuation to	E	025				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G207	B, WING	WING		11/2	20/2018
NAME OF PROVIDER OR SUPPLIER MYRTLEWOOD GROUP HOME				17	TREET ADDRESS, CITY, STATE, ZIP CODE 75 MYRTLEWOOD DRIVE IOUNT GILEAD, NC 27306		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 033	Methods for Sharing CFR(s): 483.475(c)(4) [(c) The [facility] must emergency prepared that complies with Fe and must be reviewed annually.] The commall of the following: (4) A method for shard documentation for pacare, as necessary, with maintain the continuity of the continuity of the following: (5) A means, in the erelease patient inform CFR 164.510(b)(1)(ii) required for HHAs ununder §485.68(c), an §491.12(c).] (6) [(4) or (5)]A mean about the general compatients under the [facunder 45 CFR 164.5] *[For RNHCIs at §40 sharing information a patients under the RI with care providers to care, based on the with made by the patient of representative. *[For RHCs/FQHCs at §40 sharing information and the patient of the providing information.]	Information a)-(6) It develop and maintain an iness communication plan deral, State and local laws and updated at least nunication plan must include ing information and medical tients under the [facility's] with other health providers to by of care. It went of an evacuation, to nation as permitted under 45 and in the continuity of providing information and location of acility's] care as permitted in (b)(4). 3,748(c):] (4) A method for indicate documentation for NHCl's care, as necessary, or maintain the continuity of critten election statement	1	033	By 1-19-19, the facility will develop, maintain, review, and update an Emergency Preparedness Plan that inc methods of sharing information and medication documentation, release of information, and a means of providing information about the general condition and location of the clients. The QP/R will train, monitor and update information quarterly.	client S on M	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTR ING		(X3) DATE SURVEY COMPLETED	
		34G207	B. WNG		· · · · · · · · · · · · · · · · · · ·	11,	/20/2018
	PROVIDER OR SUPPLIER			175 MYRTI	DDRESS, CITY, STATE, ZIP CODE ILEWOOD DRIVE GILEAD, NC 27306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
E 033	facility's care as perm 164.510(b)(4). This STANDARD is r Based on review of the Information and "Rist preparedness (EP) plus the facility failed to de annually update an Elincluded a method for medical documentation information, and a meabout the general conclients. The finding is Review on 11/19/18 a EP plan notebooks titl (specific client information and substantiated by intellectual disabilities revealed the facility dicomprehensive EP coincluded a method for medical documentation providers for the conticulation in the same and a means of provideneral condition and	not met as evidenced by: the facility's "Crisis sk Management" emergency lan notebooks and interview, evelop, maintain, review, and EP communication plan that or sharing information and on, release of client eans of providing information addition and the location of s: and 11/20/18 of the facility's titled "Crisis Information" ation) and "Risk ralized facility information) interview with the qualified s professional (QIDP), id not have a communication plan that or sharing information and on with other health inuity of care, release of the event of an evacuation, ding information about the if the location of clients. with the QIDP verified they unication plan to be	E	033			