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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G167	A. BUILDING ______ B. WING ______	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDLEWOOD GROUP HOME	103 WOOD GLENN ROAD ROANOKE RAPIDS, NC 27870

(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 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(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.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to develop an alternate means for communicating with staff, guardians, regional and local governments during an emergency. Review on 9/26/18 of the facility's emergency preparedness (EP) plan did not include information regarding appropriate alternate means of communication. During an interview on 9/26/18, the qualified intellectual disabilities professional (QIDP) revealed if the land line phone and cell service were down there is no other means to	E 032	E 032 The LIFE, Inc. emergency preparedness communication plan includes an alternate means for communicating with staff, guardians, regional and local governments during an emergency. The house phone will serve as the primary mode of communication. In the event that the home phone does not work, the cellular phone from the vans will be utilized as an alternate means of communication. A back-up charging device will be available as well. DHSR - Mental Health OCT 29 2018 Lic. & Cert. Section	11-24-2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara W. Parker
TITLE: Director of ICF/IID
(X6) DATE: 10-25-18

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 032	Continued From page 1 communicate during an emergency.	E 032		
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] 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.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and interviews with staff, the facility failed to develop a method for sharing their Emergency Preparedness Communication Plans as deemed appropriate with the clients residing in the facility and their guardians/representatives. The findings include: The facility did not share their Emergency Preparedness Communication Plans with the clients' and their guardians/representatives. Review on 9/26/18 of the facility Emergency Plans did not include specifics about how the Emergency Preparedness communication plans would be shared and communicated to the clients' and their guardians/representatives. There was no documentation available to review to indicate whether any information about their Emergency Preparedness Plans had been shared and discussed with any of the clients' and their guardians/representatives.	E 035	E 035 The facility will ensure that the emergency preparedness communication plan is shared with clients and their families/representatives/guardians. The QP will review the emergency preparedness communication plan with clients during home meetings. This review as well as client attendance will be documented in the minutes. All guardians were mailed a letter on 10-15-2018 which summarized LIFE's Emergency Preparedness Communication Plan, instructing them to contact the QP if they wanted a complete copy of the written plan.	11-24-2018

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E 035	Continued From page 2 During an interview on 9/26/18, the qualified intellectual disabilities professional (QIDP) confirmed they had not discussed nor presented any emergency preparedness information to any of the clients' and their guardians.	E 035		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:	E 037	E 037 LIFE, Inc. will ensure that all new and existing staff receive emergency preparedness training upon hire and annually thereafter. Documentation of this training will be will be maintained in the employees' training files, along with written testing to ensure that all employees demonstrate knowledge of the emergency procedures. The QP is responsible for this initial and annual training.	11-24-2018

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E 037	Continued From page 3 (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 4 least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 5 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to assure direct care staff were adequately trained on the facility's Emergency Preparedness policies and procedures. The finding is: Staff were not adequately trained and tested on the facility's Emergency Preparedness plans. During an interview on 9/26/18, staff revealed they had received training on fire drills and what to do if something occurs in the home. However, they had not received any training nor testing on the facility's emergency preparedness plans and they thought emergency training would be helpful. During an interview on 9/26/18, staff revealed they had not received any training nor testing on Emergency Preparedness. Further interview revealed training is needed on what to do in the	E 037		

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E 037	Continued From page 6 event of flooding like the recent floods in other cites would be helpful. Additional interview revealed they would call administration for instructions in the event of an emergency and evacuation was needed. However, staff confirmed they were told before this recent storm (Florence) what hotel to take the clients for shelter, if needed and were given money for the clients. During an interview on 9/26/18, the qualified intellectual disabilities professional (QIDP) revealed she did not have documentation available to indicate the staff in this home had been trained. Further interview confirmed the staff had not been tested on the Emergency Preparedness plans. Additional interview revealed the staff were only recently instructed on where to go and the needed emergency items for the clients (medication, food and clothing) to be taken with them in the event of relocation.	E 037		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to assure a technique used to manage a behavior was included into an active treatment program. This affected 1 of 4 audit clients (#1). The finding is: A technique used to manage a behavior during	W 288	W 288 The facility will ensure that all interventions utilized to manage inappropriate behaviors are used in conjunction with an active treatment plan. Each consumer will be re-evaluated, and their current needs will be addressed as warranted. All staff members will receive training on all changes in current Behavior Plans. The QP and Habilitation Coordinator will monitor this plan of correction to ensure compliance through the ~~compliance~~ Completion of QA/QI inspections, which will be completed a minimum of three times per month.	11-24-2018

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W 288	Continued From page 7 meals was not part of an active treatment program. During lunch observations at the day program on 9/25/18 at 12:43pm, client #1's plate was removed four times from in front of him, placed to the right side out of his reach and in front of staff. Client #1's plate was returned to him after he had chewed up the food in his mouth. Then staff stated, "chew, chew you got to chew." Staff then stated, "You got to pause, you have to pause, you're packing. You can't pause?" The staff was also manually signing stop and chew to client #1. Staff stated, "Yes, we can help you with your food. I can assist you with eating, I can put it on the fork." The staff did assist by feeding client #1 the remainder of his food. During an interview on 9/25/18, staff revealed client #1 over packs his mouth and telling him to pause is done to help him stop from doing it. Further interview revealed, "I think it's in his program to put it (plate) to the side." Review on 9/26/18 of client #1's behavior program dated 7/25/18 did not address the use of a technique to remove his plate away from in front of him while he is eating. During an interview on 9/26/18, the qualified intellectual disabilities professional (QIDP) confirmed the technique of removing client #1's plate away from in front of him while he is eating should not have been done and is not a part of an active treatment program.	W 288		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)	W 368		

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W 368	Continued From page 8 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure all medications were administered in compliance with the physician's orders for 3 of 4 audit clients (#2, #3 and #4). The findings are: The medication administrations were conducted after the physician's ordered times. During morning medication administration in the home on 9/25/18, the medications were administered after the physician's ordered times for administration. The medication orders for administration were for 6am, the window allows for the medications to be administered one hour before and up to one hour after the ordered times. The medications were administered after 7:00am; and was well after the window of an hour after the time ordered. During afternoon medication administration at the day program on 9/25/18, the medications were administered after the physician's ordered times for administration. The medication orders for administration were for 12noon, the window allows for the medications to be administered one hour before and up to one hour after the ordered times. The medications were administered after 1:00pm; and was well after the window of an hour after the time ordered. During an interview on 9/26/18, the qualified intellectual disabilities professional confirmed the	W 368	W 368 The facility will ensure that all medications will be administered according to doctors' orders. Staff will be in-serviced to ensure all medications are properly administered. This plan of correction will be monitored by the QP, the Habilitation Coordinator and the nurse through LIFE, Inc. QA/QI inspections, a minimum of three times monthly.	11-24-2018

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W 368	Continued From page 9 medication administration window is an hour before the ordered times and an hour after the ordered times. Further interview confirmed the medications were administered after the ordered times for administration.	W 368		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to teach 1 of 3 audit clients (#2) to make informed choices about the use/care of their personal adaptive equipment (eye glasses). The finding is: Client #2 was not taught to use/care for his eye glasses. During morning observations in the home and at the day program on 9/25/18, client #2 did not wear eye glasses. During the afternoon observation in the home on 9/25/18 and the dinner observations at the restaurant client #2 wore eye glasses. During morning observation in the home on 9/26/18, client #2 did not wear his eye glasses. Review on 9/26/18 of client #2's visual	W 436	W 436 The facility will ensure that all clients who utilize eyeglasses or other assistive devices receive education and training in the use and maintenance of these items. Staff will be in-serviced on the need for consistency in providing training and making informed choices about the use of these items. The QP and the Habilitation Coordinator will monitor the implementation of this plan of correction during QA/QI inspections, a minimum of three times monthly.	11-24-2018

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W 436	Continued From page 10 assessment dated 9/21/16 revealed he wears eye glasses and has a diagnosis of, "Myopia." During an interview on 9/26/18, the qualified intellectual disabilities professional (QIDP) revealed client #2 could benefit from training in the area of the care and use of his eye glasses.	W 436		