STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G206	A. BUILDING _____ B. WING _____	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSONVILLE GROUP HOME	1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007

(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 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) [(b) Policies and procedures. The [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.] At a minimum, the policies and procedures must address the following:] (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	E 018	E018 By 1-25-19, The Incident Command Center will track and document the status of each person supported and staff. Staff will be trained on this process by QP/ RM. QP/ RM will monitor quarterly. DHSR NH L & C Black Mountain MRO Received by: SKM	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Letisha Calloway	Residential Team Leader	12/4/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G206	A. BUILDING _____ B. WING _____	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSONVILLE GROUP HOME	1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007

(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 018	Continued From page 1 assistance. (v) A system to track the location of hospice employees' 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, 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 evacuees; 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 confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(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 emergency preparedness plan (EP) and substantiated by interviews, the facility failed to develop a tracking system to document the locations of clients and staff as part of the facility's EP policies and procedures. The finding is: Review on 11/26/18 and 11/27/18 of the facility's EP revealed no policies and procedures	E 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G206	A. BUILDING _____ B. WING _____	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSONVILLE GROUP HOME	1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007

(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 018	Continued From page 2 regarding a tracking system to document the locations of clients and staff in the event of an emergency. Interviews on 11/27/18 with the qualified intellectual disabilities professional (QIDP) and the home manager revealed there was no tracking system included as part of the EP to track or document locations of the staff and clients.	E 018		
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. This STANDARD is not met as evidenced by: The facility failed to assure the individual program plan (IPP) for 1 of 3 sampled clients (#4) included objective training to meet the client's behaviors as evidenced by observation, interview and record verification. The finding is: During afternoon observations in the group home on 11/26/18 between 4:20 PM to 5:00 PM revealed client #4 in the home's office removing his brown loafer shoe to show the qualified intellectual disabilities professional (QIDP) and the home manager the inside of his brown loafer shoe. Continued observations of client #4 by the surveyors also in the home's office revealed the inside of the brown loafer shoe client #4's was showing consisted of a severely worn down checkered cloth insole material. Subsequent observations at this time revealed the QIDP and the home manager to verbally acknowledge to	W 227	W227 By 1-25-19, a Personal Belonging Inventory will be completed to assess the clothing/ shoe needs for all PWS. Identified needs will be purchased for all PWS. Staff will be re-inserviced on Behavior documentation. QP/ RM will monitor quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G206	A. BUILDING _____ B. WING _____	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSONVILLE GROUP HOME	1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007

(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
W 227	Continued From page 3 client #4 the brown loafer shoe he showed them and then inform him they would soon get new shoe insoles. Client #4 then put his brown loafer shoe back on. During morning observations in the group home on 11/27/18 at approximately 8:00 AM in the hallway, client #4 removed his brown loafer shoe and showed the surveyor the inside of his shoe. Continued observations of the inside of the brown loafer shoe client #4 showed the surveyor revealed a black insole made of soft material. The surveyor acknowledged to client #4 she was viewing his shoe insole as he held it up to show and afterwards client #4 put his brown loafer shoe back on. Observations conducted on 11/27/18 at approximately 8:14 AM with staff (1) of client #4's closet in his room revealed no other shoes and no other shoes were found for client #4. Continued observation and interview with staff (1) revealed client #4 has an intermittent behavior of tearing up his shoes and they hide his shoes so he will not tear up his shoes. Subsequent interviews with another staff (1) on the whereabouts of client #4's shoes revealed no identification or presence of other shoes for client #4. In addition, interviews with the QIDP and the home manager revealed no identification or presence of other shoes for client #4 and verified client #4 has a second pair of hard shoes although they could not find them or any other shoes for client #4. Review on 11/27/18 of client #4's IPP dated 6/1/18 revealed programs to engage in physical exercise, shave, learn to swab his gums, choose clean clothes, and punch his medication pill	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G206	A. BUILDING _____ B. WING _____	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSONVILLE GROUP HOME	1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007

(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
W 227	Continued From page 4 packs. Continued review revealed a behavior support plan (BSP) with the initial plan dated 5/28/18 and updated 7/16/18, 7/20/18 and 10/11/18. Continued review of the BSP revealed objectives to decrease physical aggression, decrease self-injurious behaviors (SIB), and to decrease property destruction to 10 incidents or less per month for three consecutive months by 7/15/19. Subsequent review of client #4's BSP revealed he needs "...clear language that he can understand..." Interview with the QIDP and the home manager verified client #4 should have other shoes. Additional interview with the QIDP and the home manager revealed no team meeting documentation or any other documentation addressing client #4's behavior of tearing up and/or destroying his shoes and verified #4 currently has no objective training to address his behavior of tearing up and/or destroying his shoes.	W 227		