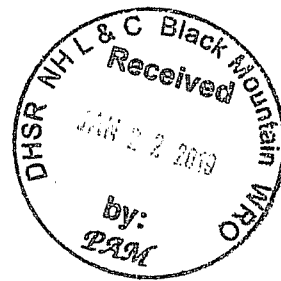


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/03/2019
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE ASHEVILLE, NC 28803		
(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 030	<p>Names and Contact Information CFR(s): 483.475(c)(1)</p> <p>[(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:]</p> <p>(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the</p>	E 030	<p>MARF's Executive Director, Operations Manager, and Board of Directors will develop a more specific Emergency Preparedness Plan which includes comprehensive communication procedures and contact lists. Staff will be trained in these new procedures and plans. This plan will be reviewed and updated annually or more frequently as needed as monitored by the Executive Director.</p>	3/4/2019	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Executive Director

1/18/19

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 030	<p>Continued From page 1</p> <p>following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Hospice employees.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Other hospices.</p> <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Volunteers.</p> <p>(iv) Other OPOs.</p> <p>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).</p> <p>This STANDARD is not met as evidenced by: Based on review of facility records and staff interviews, the facility failed to develop an Emergency Plan (EP) that included a complete communication plan as evidenced by interview and record review. The finding is:</p> <p>Review of the facility's EP, conducted on 1/2/19, revealed an EP that included communications instructions for staff to call the MARF on-call administrator in any emergency situation, after calling 911. Continued review of the</p>	E 030			

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E 030	Continued From page 2 communication section of the facility's EP, verified by interview with the Executive Director and the qualified intellectual disabilities professional, revealed no further contact information had been developed or included in the EP such as names, titles or telephone numbers.	E 030			
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group	E 039	MARF's Executive Director and Operations Manager will participate in a table-top exercise with the Mountain Area Healthcare Preparedness Coalition in order to challenge MARF's emergency plan. MARF will also participate in a full-scale community-based exercise, or if unavailable before March 4, a full-scale individual facility-based exercise. Participation in such exercises will be added to MARF's updated Emergency Preparedness Plan by the Executive Director and Operations Manager. The annual participation in these exercises will be monitored by the Executive Director.	3/4/2019	

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E 039	<p>Continued From page 3</p> <p>discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This STANDARD is not met as evidenced by: Based on a review of facility records and staff interviews, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test the current emergency preparedness plan (EP). The finding is:</p> <p>Review of the facility's EP, conducted on 1/2/19, revealed the plan did not include documentation indicating a full-scale community-based exercise or a tabletop exercise had been conducted to test their EP.</p>	E 039		

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E 039	Continued From page 4	E 039			
W 242	<p>Interviews conducted on 1/3/19 with the executive director and the qualified intellectual disabilities professional verified the facility had not conducted a full-scale community-based exercise or a tabletop exercise to test their EP.</p> <p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii)</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the person centered plan (PCP) for 1 non-sampled client (#4), included training relative to privacy. The finding is:</p> <p>Observations in the group home on 1/3/19 at 6:38 AM revealed client #4 urinating with the bathroom door open. A staff member was then observed to go down the hallway and direct the client to close the bathroom door.</p> <p>Record review on 1/3/19 for client #4, revealed a PCP dated 10/10/18. Review of the PCP did not reveal any programming related to privacy. Interview with a 3rd shift staff member on 1/3/19 revealed the client will intermittently toilet with the</p>	W 242	<p>MARF's Qualified Professional will write a staff guideline for this client's intermittent need for privacy reminders. Staff will be trained in this guideline as monitored by the Executive Director.</p>	1/23/19	

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W 242	Continued From page 5 door open. The staff per son indicated they would direct the client to close the door, if aware the client was toileting with the door open. Interview with the facility administrator on 1/3/19 confirmed client #4 did not have any programming related to privacy while in the bathroom.	W 242			
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure food was served in a form consistent with the developmental level for 1 of 3 sampled clients (#2). The finding is: Observations in the group home on 1/2/19 at 5:35 PM revealed client #2 sitting down at the dining table to begin eating the dinner meal. Client #2 was observed to be assisted with plating chopped ham, tossed salad, chopped potatoes and two whole corn muffins. The client was observed to eat all food items including the whole un-chopped corn muffins. Continued observations on 1/3/19 at 7:35 AM revealed client #2 in the kitchen assisting with preparing and plating his breakfast meal which consisted of fried eggs, banana and two halves of a bagel with jelly. The bagel halves were not cut or chopped, and client #2 was observed eating them by hand. No staff were observed prompting the client to cut or chop the muffins or bagel halves.	W 474	MARF's Qualified Professional will retrain staff in the specific dietary accommodations and orders for persons served. This will be added to the trainings done upon hire and monitored with each new hire by the Executive Director.	1/23/19	

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W 474	Continued From page 6 Review of the record for client #2 on 1/3/19 revealed a person centered plan (PCP) dated 5/21/18. The PCP contained an order dated 10/19/18 for a chopped, no added salt, low fat, high fiber diet. Further review of the PCP revealed the client had all teeth extracted and did not have dentures. Interview with the facility administrator on 1/3/19 confirmed client #2's diet included chopped consistency. The administrator also indicated staff should have assured the client's muffins and bagels were chopped before being served.	W 474			