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E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(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.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical	E 015		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This STANDARD is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to ensure emergency provisions for subsistence needs for staff and clients included adequate food and water as identified in the Emergency Preparedness (EP) plan. This affected all clients residing in the home. The finding is:

Adequate emergency food and water was not available.

Observations of the facility's emergency food/water supply revealed two boxes of ready-to-eat prepackaged meals. The box included 12 packages of food per box. Additional observation of the box noted one food package contained one serving of food. At least one of the boxes included a hand written date of 6/1/09. No expiration date was identified on the individual food packages. The emergency water supply consisted of four 1 gallon jugs of water. Further observation of the emergency food supply did not include any pureed food items.

Review of client #3 and client #5's records revealed they should consume a pureed diet.

Review of the facility's EP plan dated 8/14/18

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E 015	Continued From page 2 under Emergency Food and Water noted, "Keep a three day supply of water per person (1 gallon per person per day) ...Store a three day supply of non-perishable food ..." Interview on 2/26/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) revealed no explanation for the nine and a half year old date written on the box of food. The QIDP acknowledged this was not enough food and the food also needed to accommodate the pureed diets for two clients in the home in case of power outages.	E 015		
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	E 039		

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E 039	Continued From page 3	E 039		

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 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.
(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.

*[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:
(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.
(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.
This STANDARD is not met as evidenced by:
Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is:

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E 039	Continued From page 4 The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 2/26/19 of the facility's EP plan dated 8/14/18 did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 2/26/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 039		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 5 audit clients (#2) had to right to free movement in their home environment and all clients had the right to unblocked exits in the home. This affected all clients residing in the home. The finding is: 1. Client #2 wheelchair was locked in her home environment. During observations in the home throughout the	W 125		

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survey on 2/25 - 2/26/19, staff repeatedly locked client #2's wheelchair as she sat in the living room area of the home. Although the client's feet touched the floor, she was not able to move her wheelchair.

Staff interview on 2/26/19 revealed client #2 can move around in her wheelchair but "not if the lock is on". The staff added, "That's why we have to lock it."

Review on 2/26/19 of client #2's Physical Therapy evaluation dated 12/12/18 revealed, "[Client #2] has been observed attempting to self propel her wheelchair at home and at the workshop. For this reason,...she has been issued a lower profile cushion and her current wheelchair has been lowered to allow proper alignment required to encourage self-mobilization, increase independence, increase quality of life." Additional review of client #2's Individual Program Plan (IPP) dated 5/11/18 noted, "Staff will continue to support [Client #2] with making choices within her home and in the community. Staff will continue to informally teach [Client #2] about her rights in effort to encourage [Client #2] to make choices regarding her day to day activities."

Interview on 2/26/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) revealed staff should not be locking client #2's wheelchair unnecessarily in the home. Additional interview confirmed the client can move herself around the home using her feet while seated in her wheelchair.

2. Staff failed to ensure clients had the right to unblocked exits in the home.

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W 125	Continued From page 6 Upon arrival to the home on 2/26/19 at 5:35am, a chair was observed to be wedged against a back door leading outside and to the back of the home. The back door of the home was blocked by this chair. At 6:46 am, the chair was noted to have been removed. Interview on 2/26/19 with a third shift staff revealed they had blocked the door for "safety" reasons at night. Interview on 2/26/19 with the HM and QIDP revealed doors in the home should not be blocked for any reason and they were not aware staff had blocked the back door with a chair.	W 125		
W 203	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(5)(i) At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a final summary of a former client's status at the time of discharge was developed. This affected 1 of 1 discharged clients. The finding is: A discharge summary was not completed for a former client. Interview on 2/26/19 with the Home Manager (HM) revealed one client had passed away since the last recertification survey. The HM indicated	W 203		

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W 203	Continued From page 7 the client had been suffering from dementia and his health began to decline. The HM noted the client had passed away from natural causes. Interview on 2/26/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client # had been discharged from the facility. Additional interview indicated no discharge summary had been completed for client #1 as of the date of this survey.	W 203		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #5's Individual Program Plan (IPP) included specific information to support her independence. This affected 1 of 5 audit clients. The finding is: Client #5's IPP did not include specific information regarding her repeated sock removal behaviors. During observations at the day program on 2/25/19 from 11:05pm - 12:50pm, client #5 was not wearing any socks. Staff were not observed to place socks on the client or attempt to place sock on her feet. During observations throughout the survey in the home on 2/25 - 2/26/19, client #5 intermittently wore socks. The client consistently removed her socks and spent most of the time without any	W 240		

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W 240	Continued From page 8 socks on her feet. Staff interview on 2/26/19 revealed client #5 does not like to wear socks but they put them on her anyway because it's cold outside. Interview on 2/26/19 with day program management staff revealed client #5 often removes her socks and does not like some shoes she wears to the day program. The staff indicated all clients are required to wears shoes and socks to attend the day program. Review on 2/26/19 of client #5's Behavior Support Plan dated 8/21/18 revealed an objective to address self-injurious behavior (SIB). The BSP also noted, "other behaviors she may exhibit include: ripping her/peers clothes, stripping of clothes/diapers and hair pulling". Additional review of the client's Individual Program Plan (IPP) dated 8/21/18 did not include any specific information regarding the client's sock removal tendencies or how to respond to this behavior. Interview on 2/26/19 with the Home Manager (HM) and Qualified Intellectual Disabilities (QIDP) indicated client #5 frequently removes her socks and does not like to wear them. The HM also revealed shoes and socks sent to the day program each day and should be placed on the client.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed	W 249		

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interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions as identified in the Individual Program Plan (IPP) in the areas of dining skills, self-help skills, grooming, and adaptive equipment use. This affected 4 of 5 audit clients. The findings are:

1. Client #5's adaptive dining equipment was not used at the day program.

During observations at the day program on 2/25/19 at 11:30am, client #5 fed herself approximately 4 - 5 bites of food using a built-up handle spoon from a deep dish sectioned plate. As the client scooped, staff seated next to her held the plate several inches off the table and close to the client's chest. The staff then returned the plate to the table and began feeding client #5. At the meal, no dycem mat or plate riser was used and the client was not observed to exhibit any inappropriate behaviors.

Interview on 2/25/19 with the staff involved revealed client #5 is fed her meal after several bites of food due to behaviors.

Review on 2/26/19 of client #5's Occupational Therapy update dated 1/7/19 revealed, "Please encourage pt to participate in self-feeding. Staff

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should offer assistance as needed with loading utensil and bringing it to mouth, fade prompts as necessary ...offer close supervision and one on one assistance with self feeding, due to the potential for SIB or property destruction (pushing away and throwing plate riser) ...The use of following dining room equipment is necessary for increasing independence with feeding.
Plate-raiser, Hi Low Dish, Built up Right angled spoon, Regular cup ...Dycem mat."

Interview on 2/26/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) they were told by the Occupationa Therapy (OT) that client #5's plate riser was "prn" or as needed and she could be fed after several bites of food. The QIDP indicated this needed to be clarified with the OT.

2. Client #2 and client #3 were fed during the administration of their medications.

During dinner and breakfast meals in the home on 2/25/19 and 2/26/19 at 6:12pm and 7:22am, respectively, client #2 fed herself given physical assistance while client #3 consumed her meal given verbal prompts. Both clients required adaptive spoons and plates at the meals.

During evening observations of medication administration in the home on 2/25/19 4:25pm and 4:38pm, staff fed client #2 and client #3 their medications using adaptive spoons.

Staff interview on 2/26/19 revealed client's adaptive dining utensils and equipment is used during the medication pass so they can assist with feeding themselves.

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Review on 2/26/19 of client #2's IPP dated 5/11/18 revealed she used a built-up handled spoon/fork and high sided divided plate at meals.

Review on 2/26/19 of client #3's IPP dated 5/15/18 indicated she used a built-up handles angle spoon and scoop plate at meals.

Interview on 2/26/19 with the HM confirmed clients who require adaptive dining equipment should be assisted to utilize it during the administration of their medications.

3. Clients (#2, #3, #5) were not prompted or assisted to set their place settings and clear their dishes after meals.

During evening observations in the home on 2/25/19, three clients were prompted and/or assisted to set their places at the table. Other clients (#2, #3, #5) were not prompted or encouraged to set their places before dinner.

During additional observations after breakfast on 2/26/19, four clients were prompted and/or assisted to clear their dirty dishes after the meal. Client #2 and client #5 were not prompted or encouraged to clear their dishes from the table.

Staff interview on 2/26/19 revealed client #2 can set her place and clear it with hand-over-hand assistance. Additional interview indicated client #5 can probably set and clear her place with full physical assistance since she has a tendency to throw items.

Review on 2/26/19 of client #2's IPP dated 5/11/18 revealed, "Continue to provide [Client #2] with physical assistance when needed. Always

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W 249	Continued From page 12 ...attempt to promote independence." Review on 2/26/19 of client #3's IPP dated 5/15/18 indicated, "[Client #3] will be encouraged to participate in ADL's to maintain and/or further increase her independence whenever possible through informal and formal training objectives." Review on 2/26/19 of client #5's IPP dated 8/21/18 noted, "[Client #5] will continue to be encouraged to participate in ADL's to maintain and/or further increase her independence whenever possible through informal and formal training objectives." Interview on 2/26/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients (#2, #3, #5) are capable of assisting with setting and/or clearing their dishes given assistance. 4. Client #6's fingernails were in need of grooming. During observations throughout the survey on 2/25 - 2/26/19, client #6's fingernails were long and extending well beyond the tips of his fingers. Staff interview on 2/26/19 revealed 2nd shift staff usually clips the client's fingernails after given instructions from the nurse. Review on 2/26/19 of client #6's appearance check list revealed no documentation that his fingernails had been cut during January 2019 and February 2019 (up to the date of the survey). Interview on 2/26/19 with the HM revealed staff usually clip client's fingernails on the weekends and whenever needed.	W 249		

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W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #5's Behavior Support Plan (BSP) was reviewed and revised after she had completed the objective. The finding is: Client #5's BSP was not reviewed after she had completed the objective. Review on 2/26/19 of client #5's BSP dated 8/21/18 revealed an objective to exhibit 0 episodes of SIB/Mitten use for hair pulling per month for 12 consecutive months. Additional review of monthly progress notes for the objective dated September 2017 - January 2019 indicated 0 episodes of SIB and Mitten use. Interview on 2/26/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) revealed the home has been without a Psychology consultant for over a year. Additional interview indicated therehave not been any changes to client #5's BSP.	W 255		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs	W 312		

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	34G292	A. BUILDING _____ B. WING _____	02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKWOOD	4409 ROCKWOOD DRIVE RALEIGH, NC 27612

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W 312	Continued From page 14 are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure drugs used for the control of inappropriate behaviors were used only as an integral part of the Behavior Support Plan (BSP) directed towards the reduction or elimination of behaviors for which the drugs were employed. This affected 2 of 5 audit clients (#4, #5). The finding is: 1. Client #5's use of behavior medications continued to be administered without target behaviors being exhibited. Review on 2/26/19 of client #5's BSP dated 8/21/18 revealed an objective to exhibit 0 episodes of SIB/Mitten use for hair pulling per month for 12 consecutive months. Additional review of monthly behavior progress notes dated September 2017 - January 2019 for the objective indicated 0 episodes of SIB and Mitten use for nearly 17 months. During an interview on 2/26/19 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged client #5's behavior data did not justify the use of her current behavior medications. The QIDP indicated no changes have been made to the BSP or the medications used to address inappropriate behaviors. 2. Client #4's use of Remeron was not included in an active treatment plan. Review on 2/26/19 of client #4's current physician's orders dated 3/1/19 revealed an order	W 312		

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W 312	Continued From page 15 for Remeron 7.5, take one tab by mouth nightly "for sleep". Additional review of the client's BSP dated 11/12/18 also identified the use of Melatonin for sleep. The record did not include the use of Remeron in a formal active treatment plan. Interview on 2/26/19 with the QIDP confirmed the use of Remeron was not included in a formal active treatment plan. 3. Strategies to address client #4's sleep behavior were not included in his BSP. Review on 2/26/19 of client #4's BSP dated 11/12/18 revealed objectives to address failure to cooperate, agitation, property destruction, physical aggression and elopement. Additional review of the plan included the use of Melatonin for sleep. Further review of the client's current physician's orders noted an order for Remeron 7.5, take one tab by mouth nightly "for sleep". Further review of client #4's BSP did not include specific strategies to address his sleep issues. Interview with the HM and QIDP revealed client #4 often does not sleep well and he was admitted to the facility with Melatonin and the Remeron was recently added since it was felt the Melatonin was not very effective. The QIDP acknowlegded the drugs used for sleep were in place without specific strategies to address his sleep issues.	W 312		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature.	W 473		

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W 473	Continued From page 16 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all foods were served at an appropriate temperature. This affected all clients residing in the home. The finding is: Foods were not served at an inappropriate temperature and/or within 15 minutes of removal from its heating source. During dinner preparation observations in the home on 2/25/19 at 5:40pm and 5:45pm, pork loin and potatoes, respectively, were removed from the oven. Cabbage was placed in bowls at 5:50pm and biscuits were removed from the oven at 5:57pm. Staff blended the food items separately in a blender adding milk from the refrigerator to some foods to obtain a pureed consistency. The temperature of the food was not taken before serving and food was not reheated. Clients began consuming food items at 6:12pm. Review of a sample menu sheet revealed, "All hot food and beverages must be held at 140 or higher. All cold food and liquids must be held at 40 or lower. Once item take from heat keeping and/or cold keeping devices they must be served to clients within 15 minutes or reheated to 165, then served." Interview on 2/26/19 with the Home Manager revealed thermometers are located in the home for the purpose of taking food temperatures.	W 473		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4)	W 488		

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W 488	Continued From page 17	W 488		

The facility must assure that each client eats in a manner consistent with his or her developmental level.

This STANDARD is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure clients ate in a manner which was not stigmatizing. This affected 2 of 5 audit clients (#2, #5). The finding is:

Clients were not assisted to eat in a manner which was not stigmatizing.

During morning observations in the home on 2/26/19 at 7:22am, staff began assisting clients to the table for breakfast. At this time, staff secured the upper portion of an apron around client #2 and client #5's neck. The lower portion of the apron was then placed underneath plate risers which were used by both clients at the meal. Moderate spillage was noted by each client while eating.

Staff interview on 2/26/19 revealed the aprons had been positioned in this manner so "food won't drop on the floor...so it won't be messy." The staff indicated, "That's why I do it."

Review on 2/26/19 of client #2's Individual Program Plan (IPP) dated 5/11/18 revealed she utilizes an apron at meals. The plan, however, did not indicate she should consume her meals in this manner.

Review of client #5's IPP dated 8/21/18 did not indicate she should consume her meals in this manner.

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W 488	Continued From page 18 Interview on 2/26/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) revealed the clients should not be eating with their arpons postitioned in this manner.	W 488		