STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G241	A. BUILDING ______ B. WING ______	04/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER	**5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106**

(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 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on review of facility records and interviews, the facility failed to assure the Emergency Preparedness Plan (EPP) contained specific current information relative to the needs of all clients residing in the home. The finding is: Review on 4/1/19 of the facility's EPP manual titled "Horizons Emergency Preparedness Manual" with an effective date of 2/16/18 revealed no client specific information pertaining to individual support plans (ISPs) and behavior support plans (BSPs). Further review revealed no specific information regarding client identification, personal care and adaptive equipment needs. Interview on 4/2/19 with the qualified intellectual disabilities professional (QIDP) verified client specific information should be included in EPP to enable persons unfamiliar with each client to provide appropriate, safe care during an	E 007		

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

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 007	Continued From page 1 emergency evacuation.	E 007		
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	E 015		

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E 015	Continued From page 2	E 015		

evacuate or shelter in place, include, but are not limited to the following:

(A) Food, water, medical, and pharmaceutical 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 observations, review of facility records, and interviews the facility failed to implement the emergency preparedness plan (EPP) relative to the provisions of sustenance needed for clients and staff. The finding is:

Observations on 4/1/19 and 4/2/19 of the facility's designated area of emergency supplies identified by a posted wall sign noting "Emergency Supplies" revealed 3 flat canned soup cases, 4 instant oatmeal cases, several cases of enteral feeding containers, several containers and cases of water supplies.

Review on 4/1/19 of the facility's EPP manual titled "Horizons Emergency Preparedness Manual" with an effective date of 2/16/28 revealed a general list of supply needs to include bedding, towels, flashlights, medical and First Aid care needs. Further review revealed no policy or information pertaining to the sustenance provision needs for clients and staff.

Interview on 4/1/19 with the qualified intellectual disabilities professional (QIDP) revealed they

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E 015	Continued From page 3 currently have a 5-7 day supply of emergency foods. Further interview revealed the facility's current emergency supply of food had recently undergone rotation processes and this explains why there is only canned soup and instant oatmeal. Interview on 4/2/19 with the QIDP and the Director of Nursing (DON) confirmed a sufficient, variety of non-perishable food items should be maintained in the facility's designated area of emergency supplies at all times to ensure provisions of sustenance for clients and staff.	E 015		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure privacy of 3 of 3 sampled clients #1, #8, and #9 during medication administration. The finding is: Observations conducted on 4/2/19 at 7:25AM to 8:00 AM in the home revealed clients #1, #8, and #9 were in a common room, the den, along with other clients to include clients #2, #3, #4, #7, and client #10 as they were having their breakfast. Continued observations revealed client #9 to receive her medications via G tube at 7:25 AM in the den with other clients present and without the use of a screen or other mode of privacy. Further observation at 7:45AM revealed client #1 to receive her medications with other clients present	W 130		

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W 130	Continued From page 4 in the den without the use of a privacy screen or another privacy method. Subsequent observation of client #8's medication administration via G-J tube at 8:00AM revealed client #8 was administered his medications in the great room with all clients present and without the use of a privacy screen or another mode of privacy. Interview with the facility nurse and the qualified intellectual disabilities professional (QIDP) on 4/2/19 confirmed a screen or another mode of privacy should be provided for all clients during the treatment and care of personal needs to include the administering of individuals' medications.	W 130		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on facility record reviews and interviews, the facility failed to provide an analysis related to the timeliness of evacuations during 6 of the 12 evacuation drills conducted during the the past year. The findings is: Review on 4/1/19 of the facility evacuation drill records revealed the records of evacuations conducted on 3/29/19 for 3rd shift, 1/2019 for 3rd shift, 9/18/19 for 3rd shift, 7/31/18 for 1st shift, 6/28/18 for 3rd shift, and 5/7/18 for 2nd shift had not been completed with evacuation times. Therefore the facility was not able to evaluate and analyze the timeliness of these evacuation drills.	W 448		

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W 448	Continued From page 5 Interview conducted on 4/2/19 with the facility qualified intellectual disabilities professional (QIDP) and the facility director of nursing verified these evacuation drills were incomplete and did not allow for the proper analysis of the evacuation process.	W 448		