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
	34G169	A. BLDG. _____ B. WING _____	04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDWAY GROUP HOME	202 FRIENDWAY ROAD GREENSBORO, NC 27409

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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 information relative to 6 of 6 clients residing in the home (#1, #2, #3, #4, #5, and #6). The finding is: Review on 4/15/19 of the facility's EPP revealed no client specific information was included in the plan. Further review of the EPP on 4/15/19, verified by interview with the qualified intellectual disabilities professional (QIDP), revealed the facility had not included specific information in the EPP pertaining to client needs, preferences, means of communication, behavioral information or medical support needed which would enable persons unfamiliar with each individual client to provide care during an emergency.	E 007	The facility will ensure that the Emergency Preparedness Plan (EPP) is updated to include client specific information relative to their preferences, behavioral needs, mode of communication and medical support to promote safety and the provision of optimal care during an emergency. A clinical meeting will be scheduled by the QP; and updates to the EPP will take place to address specific client information. The QP will provide in-service training on the updated EPP to all applicable staff. The ICF Director and/or QA will monitor in the EPP monthly to ensure continued compliance.	6/14/19 6/14/19
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4)	E 009		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Jacobs | TITLE: COO | (X6) DATE: 5/6/19

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 009	Continued From page 1 [(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:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: The facility failed to develop an Emergency Preparedness Plan (EPP) which included a process for cooperation and collaboration with local, state and federal emergency preparedness officials' efforts of an integrated emergency response or documentation of the facility's efforts to contact such officials as evidenced by interview and record verification. The finding is:	E 009	The facility will ensure that the Emergency Preparedness Plan (EPP) is updated to include contact with local management resources available in the community for direct access -in case of a need for immediate coordinated evacuation. 6/14/19 The QP will contact local resources and coordinate collaborative efforts with local, state, regional and federal officials to ensure an organized effort in the event of immediate evacuation. The QP will document these coordinative efforts and involved entities in the EPP for dissemination to all applicable parties. 6/14/19 A clinical meeting will be scheduled by the QP; and updates to the EPP will be discussed. The QP will provide in-service training on the updated EPP to all applicable staff. The ICF Director and/or QA will monitor the EPP monthly to ensure continued compliance.	

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E 009	Continued From page 2 Review on 4/15/19 of the facility's EPP revealed no documentation that contact has been made with local emergency management resources to determine what is available locally in case evacuation is not possible. Further interview on 4/15/19 revealed the EPP was only developed by the facility as of 12/2018. Interview on 4/16/19 with the qualified intellectual disabilities professional (QIDP) revealed the facility's EPP does not include documentation of efforts on their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials for an integrated response during a disaster or emergency situation.	E 009		
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 observations, record review and interviews the facility failed to provide privacy for 1 of 4 sampled clients (#4). The finding is: Observations in the group home on 4/16/19 at 7:14 AM revealed client #4 entering the hallway bathroom. Continued observations at 7:16 AM revealed staff D entering the bathroom without knocking on the bathroom door. Further observations at 7:17 AM revealed Staff D leaving the bathroom, getting tissue from the adjacent bathroom and returning to the bathroom where client #5 was utilizing. Subsequent observations	W 130		

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W 130	Continued From page 3 revealed staff B standing in the bathroom door way with the door open instructing client #4 to "wipe and wash his hands" and to "scrub them" and to "close the seat" until 7:19 AM when client #4 exited the bathroom. Interview with the qualified intellectual disabilities professional (QIDP) on 4/16/19 revealed all staff have been trained to respect clients' privacy. Continue interview with the QIDP confirmed staff should always knock on all closed doors before entering a clients' private space. Further interview with the facility QIDP verified the door should remain closed when attending to clients' personal needs of toileting, dressing, and other needs that require exposure of one's body.	W 130	The facility will ensure that privacy is promoted for all cleints during care of personal needs. The Qualified Professional (QP) will provide additional training to all paraprofessionals in the home on the importance of client privacy during care of their personal needs such as use of the bathroom and/or other toilet facilities. Staff will be instructed to not stand in the door way while attending to cleints in the bathroom but instead should close the door after entering the bathroom to address client needs as applicable. The QP and/or home manager will conduct morning and evening observations in the home weekly to ensure privacy during personal care and/or treatment of personal needs.	6/14/19
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 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 observation, record review and interview the facility failed to provide continuous training to support the achievement of an objective identified in the program plan for 1 of 3 sampled clients (#3). The finding is: Observations in the group home at 8:08 AM on	W 249	The facility will ensure that medication administration training is implemented for all cleints as outlined in the program plan.	6/14/19

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W 249	Continued From page 4 4/16/19 revealed client #3 was prompted by staff to go the medication room to receive her morning medications. Further observations revealed client #3 to receive her morning medications consisting of Cetirizine, Fluvoxamine, Levetiracetam, Seroquel, and multi-vitamin. Continued observations revealed staff to assist client #3 to punch her medications into a medication cup, which she self administered with 8 ounces of water. Further observations revealed at no time during the medication administration did staff teach to client #3 the names of the medications, purposes or side effects of the medications administered, or give client #3 an opportunity to identify her medications or verbalize the effects of those medications. Record review for client #3 on 4/16/19 revealed a current Habilitation Plan dated 1/4/19 which contained a program objective for client #3 to "identify and verbalize the effects of 1 of her medications one time weekly for 30 days times 9 months." Interview with the qualified intellectual disabilities professional (QIDP) on 4/16/19 confirmed staff had been trained to teach clients daily the names, purpose and possible side effects of their medications during medication administration. Continued interview with facility QIDP confirmed staff should have provided teaching to client #3 during her medication administration regarding the names, purpose and side effects of all of her medications, and offered her an opportunity to identify and verbalize the effects of one of her medications during her medication administration.	W 249	The QP will provide in-service training to all paraprofessional staff on applicable medication administration training. For Client #3 staff will implement training on the name, purpose and side effects of her medications as outlined in the program plan. The home manager and QP will monitor the morning medication pass routine in the home twice weekly to ensure compliance.	6/14/19 6/14/19
W 331	NURSING SERVICES CFR(s): 483.460(c)	W 331		

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W 331	Continued From page 5 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure that 1 non-sampled client (#2) reported to have recently sustained right eye trauma had documentation of nursing assessments, all treatments used, and client progression in her record. The finding is: Observations throughout the survey on 4/15/19 to 4/16/19 revealed the skin surface underneath client #2's right eye had black, blue discoloration accompanied by swelling. Interview on 4/15/19 with staff A revealed on 4/12/19 client #2 had injured her right eye in the shower after the showerhead had slipped out of her hand and hit her right eye. Further interview revealed staff D called the facility nurse on 4/12/19 about client #2's right eye injury. Continued interview on 4/15/19 with staff A revealed during the phone call on 4/12/19 the nurse instructed staff D "to put ice on it." Ongoing interview on 4/15/19 with staff A revealed the facility nurse did not come to the group home to assess client #2's right eye and she was not aware if the nurse has seen client #2's right eye. Review on 4/15/19 of the group home's communication book revealed an entry dated 4/12/19 noted "[Client #2] has a bruise under her right eye that she got at shower time." Further review on 4/16/19 of a facility incident report signed completed on 4/12/19 revealed on 4/12/19	W 331	The facility will ensure the provision of nursing services to address client injuries and other such incidents requiring medical attention. The QP will meet with the RN to discuss timely assessment, treatment and follow-up to address client injury and progression of health status. The RN will monitor client #2 and other clients and document accordingly in the record to address injuries, health status. The RN will monitor and complete continued documentation in the nursing notes to support follow-ups until client recovery from illness or injury. The QP will monitor documentation of nursing notes weekly to ensure compliance. The QA and/or ICF Director will provide such monitoring twice monthly to ensure compliance	6/14/19 6/14/19

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W 331	Continued From page 6 at 6:30 PM "[Client #2] got in the shower and turn on the...she then reached for the detached showerhead. It slipped out of her hand and hit her in the face. I asked her if she was ok and she reply 'It a shame.'" Continued review on 4/16/19 of the facility incident report revealed no medical documentation of client #2's right eye trauma. Ongoing review on 4/16/19 of client #2's current record revealed no found or provided nursing service progress notes pertaining to her right eye trauma. Interview on 4/16/19 with the facility nurse over the phone revealed group home staff called her on 4/12/19 about client #2's right eye trauma and she instructed staff to put ice on client #2's right eye. Further interview with the facility nurse revealed she was on call during her vacation on 4/12/19 and did not see client #2's right eye until 4/15/19. Continued interview revealed client #2 has an eye appointment on 4/17/19 to have her right eye examined. Additional interview on 4/16/19 with the facility nurse confirmed she did not document client #2's care and confirmed she should document all client care in client records and in facility incident report records. Interview on 4/16/19 with the qualified intellectual disabilities professional (QIDP) revealed he became concerned over client #2's right eye discoloration and contacted the facility nurse about client #2's right eye bruising. Further interview confirmed client #2 has an upcoming eye appointment on 4/17/19 for her right eye trauma. Additionally, the QIDP confirmed all nursing care administered should be properly documented.	W 331		
W 371	DRUG ADMINISTRATION	W 371		

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W 371	Continued From page 7 CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to provide needed interventions to support the achievement of teaching clients to administer medications for 2 sampled clients (#6 and #3). The findings are: A. Observations in the group home at 7:50 AM on 4/16/19 revealed client #6 was prompted by staff to go the medication room to receive her morning medications. Further observations revealed client #6 to receive her morning medications consisting of Polyethylene glycol, Clonazepam, Depakote, ferrous sulfate, theorems, along with vitamin D and E tablets. Continued observations revealed staff to assist client #6 to punch her medications into a medication cup, which she self administered with 8 ounces of water. Further observations revealed at no time during the medication administration was there teaching to client #6 of the names of her medications, their purposes or side effects. Interview with the qualified intellectual disabilities professional (QIDP) on 4/16/19 confirmed staff had been trained to teach clients the names, purposes and possible side effects of their medications. Continued interview confirmed staff should have provided teaching to client #6 during	W 371	The facility will ensure that staff teach clients all aspects of medication administration skills to include increasing their knowledge of medications administered. For Cleints #3 and #6 the QP will provide in-service training to all paraprofessional staff on the name of medications, purpose and side effects as outlined in their program plans. For Clients #3 and #6 staff will implement training on the name, purpose and side effects of their medications as outlined in their program plans. The home manager and QP will monitor the morning medication pass routine in the home twice weekly to ensure compliance	6/14/19 6/14/19

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W 371	Continued From page 8 her medication administration regarding the names, purpose and side effects of all her medications. B. Observations in the group home at 8:08 AM on 4/16/19 revealed client #3 was prompted by staff to go the medication room to receive her morning medications. Further observations revealed client #3 to receive her morning medications consisting of Cetirizine, Fluvoxamine, Levetiracetam, Seroquel, and multi-vitamin. Continued observations revealed staff to assist client #3 to punch her medications into a medication cup, which she self administered with 8 ounces of water. Further observations revealed at no time during the medication administration was there teaching of medication names, purposes or side effects of client #3's medications. Interview with the QIDP on 4/16/19 confirmed staff have been trained to teach clients the names, purpose and possible side effects of their medications. Continued interview confirmed staff should have provided teaching to client #3 during her medication administration regarding the names, purpose and side effects of all of her medications. Further interview confirmed staff should have offered client #3 an opportunity to identify and verbalize the effects of one of her medications during her medication administration as stated in her program objective.	W 371		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration.	W 382		

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W 382	Continued From page 9 This STANDARD is not met as evidenced by: Based on observations and interviews the facility to to ensure all drugs and biologicals remained locked. The finding is: Observations on 4/16/19 at 7:55AM in the group home revealed client #6 was directed to a medication room attached to the kitchen area to receive her morning medications. Continued observations revealed staff B to unlock the medicine cabinet and begin to measure out an amount of Polyethylene glycol but stated he " was not sure if the measurement device was accurate." Further observations revealed staff B to exit the medication room going into the kitchen leaving the medication closet door opened and unlocked, with client #6 sitting directly in front of the open medication closet. Continued observations revealed client #6 to reach into the medication closet, however, she did remove any medications. Further observations revealed staff to return to the medication room to complete the administration of client #6's medications consisting of Polyethylene glycol, Clonazepam, Depakote, ferrous sulfate, theorems, vitamin D tablet and a vitamin E tablet. Interview with the qualified intellectual disabilities professional (QIDP) confirmed staff have been trained to keep the medication closet and the medication room locked at all times when not present and to exit clients from the medication room as staff exit the medication room. Further interview with the QIDP revealed staff may have been "nervous and forgotten what to do." Continued interview with the QIDP confirmed staff should not have exited the medication room leaving the client inside with the medication closet	W 382	The facility will ensure that staff secure medications at all times. Staff will always provide direct supervision of medication during the medication pass with no exceptions. The QP will provide in-service training to all paraprofessional staff on the importance of securing the medications and direct supervision of medications during the med pass. The home manager and QP will monitor the morning medication pass routine in the home twice weekly to ensure compliance	6/14/19 6/14/19

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W 382	Continued From page 10 unlocked, while he searched for a measurement device in the next room. Subsequent interview with the QIDP confirmed all pharmaceuticals should be kept locked at all times to prevent access to anyone who is not administering medications.	W 382	The facility will ensure a sanitary environment to prevent the transmission of infection and/or cross-contamination.	6/14/19
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of infection and to prevent possible cross- contamination. This potentially affected all clients residing in the home. The finding is: Morning observations on 4/16/19 at 6:30 AM in the group home revealed 5 sandwiches consisting of deli meats and a container of macaroni salad to sit out on a kitchen counter. Further observations on 4/16/19 at 7:30 AM in the group home revealed a first shift staff member H to put the 5 sandwiches and the container of macaroni salad into 2 lunch bags and immediately afterwards to place the 2 lunch bags into the home's refrigerator. Interview on 4/16/19 with staff H at 7:30 AM revealed the 5 deli meat sandwiches had mayonnaise and neither the sandwiches nor the container of macaroni salad should have been left out of the refrigerator for an hour.	W 454	The QP will provide in-service training to all paraprofessional staff on appropriate storage of deli meats, macaroni salad and/or mayonnaise-based food items. Staff will be advised to store under appropriate cold temperatures such as placement in the refrigerator. The home manager and QP will monitor during the morning routine in the home twice weekly to ensure compliance	6/14/19

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W 454	Continued From page 11 Interview on 4/16/19 with the qualified intellectual disabilities professional (QIDP) confirmed the 5 deli meat sandwiches with mayonnaise and the container of macaroni salad should not have been left out of the refrigerator.	W 454		