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	34G026	A. BUILDING _____ B. WING _____	04/18/2019

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NEW RIVER COTTAGE INC	82 DAVIS LANE SPARTA, NC 28675

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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 interview, the facility failed to assure the emergency plan (EP) contained specific information relative to 5 of 5 clients residing in the home (#1, #2, #3, #4 and #5). The finding is: Review of the facility's EP, conducted on 4/17/19 and 4/18/19, revealed no client specific information was included in the plan. Further review of the EP, verified by interview with the qualified intellectual disabilities professional/program manager on 4/18/19, revealed the facility had not developed or included specific information in the EP regarding client's needs, preferences, means of communication, behavioral information or medical support needed which would enable persons unfamiliar with each client to provide care during an emergency.	E 007	RECEIVED MAY 6 2019 DHSR NH L & C Black Mountain / WRO The facility, New River Cottage will develop a client specific information that will be included in the emergency plan for the facility. The information will be reviewed and updated as needed by the QIDP on an annual basis. The information to be included in the client specific plan will include at a minimum each clients needs, preferences, means of communication, behavioral information or medical support needed for each of the 5 clients that will enable persons unfamilar with each client to provide care during an emergency.	6/17/19
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b)	E 013		

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

Director / QIDP — 6/2/19

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 013	Continued From page 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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These	E 013		

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E 013	Continued From page 2 emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on review of facility records and interview, the facility failed to develop policies and procedures based on the facility's emergency preparedness plan (EP). The finding is: Review of the facility's EP, conducted on 4/17/19 and 4/18/19, revealed a document entitled Emergency Action Plan was posted on the bulletin board located in the office of the home along with a list of emergency contact telephone numbers for local and regional agencies as well as contact numbers for the facility's executive director and the program director. Further review of the document entitled Emergency Action Plan revealed a list of instructions for staff to follow in the event of specific emergencies. Interview conducted with the qualified intellectual disabilities professional/program director conducted on 4/18/19 revealed no further policies and procedures had been developed based on the Emergency Action Plan at this time.	E 013	The facility will develop & implement a emergency preparedness policies & procedures based on the document: Development of EP Policies & Procedures CFR(s): 483.475(b), 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. These policies and procedures will be reviewed annually and updated as needed by the QIDP for the facility.	6/17/19
E 029	Development of Communication Plan CFR(s): 483.475(c) (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. This STANDARD is not met as evidenced by: Based on review of facility documents and	E 029		

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E 029	Continued From page 3 interview, the facility failed to develop specific policies and procedures to address emergency preparedness including a specific communication plan that complies with federal, state and local laws and is updated at least annually. The finding is: Review of the facility's EP, conducted on 4/17/19 and 4/18/19, revealed a document entitled Emergency Action Plan was posted on the bulletin board located in the office of the home along with a list of emergency contact telephone numbers for local and regional agencies and contact numbers for the facility's executive director and program director. Further review of the document entitled Emergency Action Plan revealed a list of instructions for staff to follow in the event of specific emergencies, however, the EP did not include current policies and procedures regarding communication means (primary or alternate) during any emergency/disaster situation. Interview with the qualified intellectual disabilities professional/program director conducted on 4/18/19, revealed no specific policies and procedures had been developed relative to primary or alternate means of communication during an emergency/disaster situation.	E 029	The facility will develop and maintain an emergency preparedness communication plan (epcp) that will comply with Federal, State and local laws. The epcp will be reviewed annually and updated as needed by the QIDP. 6/17/19	
W 183	FACILITY STAFFING CFR(s): 483.430(c)(2) There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: (i) Clients for whom a physician has ordered a	W 183		

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W 183	Continued From page 4 medical care plan; (ii) Clients who are aggressive, assaultive or security risks; (iii) More than 16 clients; or (iv) Fewer than 16 clients within a multi-unit building. This STANDARD is not met as evidenced by: Based on review of facility staffing schedules and staff interviews, the facility failed to provide 24-hour awake staff supervision on weekends for 5 of 5 clients residing in the group home (#1, #2, #3, #4 and #5). The finding is: Review of facility staffing schedules, conducted on 4/17/19 and 4/18/19, revealed two staff were scheduled for first and second shifts throughout the week, with one awake staff scheduled during the night during the week. Continued review of the facility's staffing schedule revealed staff scheduled on each weekend included one staff working from 6:00 AM on Saturday until 6:00 AM on Monday, with one staff working from 6:00 AM until 10:00 PM on Saturday and Sunday. Review of facility and individual records for all 5 clients revealed sleep records for each client were documented and no incidents or injuries were documented as having occurred during the overnight hours on weekends. Interviews conducted on 4/17/19 with direct care staff A and B revealed the staff scheduled from 6:00 AM Saturday until 6:00 AM Monday slept in the group home during overnight hours on the weekends. Interview conducted on 4/18/19 with the qualified intellectual disabilities professional verified one staff was scheduled to work from 6:00 AM Saturday until 6:00 AM Monday each	W 183		

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W 183	Continued From page 5 weekend, with another staff working from 6:00 AM until 10:00 PM both days. This interview further verified the weekend overnight staff was allowed to sleep for at least 5 hours each night on the weekends.	W 183	The facility will make the necessary changes to facility staffing that will comply with the requirement that direct care staff will be on duty and awake on a 24-hour basis when clients are present. The QIDP will adopt	
W 331	NURSING SERVICES CFR(s): 483.460(c) 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 interview, nursing services failed to assure staff were trained to provide teaching for 5 of 5 clients observed during medication administration (#1, #2, #3, #4 and #5), and failed to provide medical assessment and monitoring for 1 of 3 sampled clients (#4) following an injury. The findings are: A. Nursing services failed to assure staff were trained to provide teaching for 5 of 5 clients observed during medication administration. 1. Observations conducted on 4/18/19 at 7:00 AM revealed staff entered the medication administration area and prepared medications for client #1 including Divalproex 125 mg. -three tablets and Diphenhydramine 25 mg. - one capsule. These medications were given to client #1 in food at breakfast. No information was provided by staff for client #1 regarding the name, purpose or possible side effects of his medications, and client #1 was not prompted to participate in any way during the administration of his medications.	W 331	new schedules that will maintain awake staff at all times.	6/17/19

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W 331	Continued From page 6 2. Observations conducted on 4/18/19 at 7:30 AM revealed client #3 was prompted by staff to enter the medication administration area where she was assisted by staff to receive medications including Ferrous Sulfide 32.4 mg., Lisinopril 20 mg., Loratadine 10 mg., Omeprazole 20 mg., Sertraline 100 mg. and Flonase nasal spray-two sprays to each nostril. Client #3 was observed to self-administer the Flonase nasal spray, however, staff did not provide client #3 with information regarding the names, purpose and possible side effects of her medications. 3. Observations conducted on 4/18/19 at 7:35 AM revealed client #5 was prompted by staff to enter the medication administration area where she was assisted by staff to receive medications including Aripiprazole 10 mg.-one tablet, Centrum Silver-one tablet, Lisinopril 20 mg.-1 and 1/2 tablets, Potassium ER 10 meq. -one tablet, Venlafaxine ER 150 mg.- one tablet, Metformin XR 500 mg. -one tablet and Vascepa 1 GM-one tablet. Staff was not observed to provide client #5 with information regarding the names, purpose and possible side effects of her medications. Review of the record for client #5, conducted on 4/18/19 revealed physician's orders dated 3/19/18 revealed client #5 should receive Metformin XR 500 mg.-two tablets by mouth twice daily. Continued review or the record for client #5 revealed a physician's order dated 4/4/19 revealed client #5 should receive Vascepa 1 GM -two tablets twice daily. 4. Observations conducted on 4/18/19 at 7:45 AM revealed client #2 was prompted by staff to enter the medication administration area where he was assisted by staff to receive medications	W 331		

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W 331	Continued From page 7 including Centrum Silver -one tablet, Risperidone 3 mg., Paroxetine 20 mg., Vitamin D-3 1000 units-two capsules by mouth as well as topical medications including Gold Bond cream to feet and legs, Cetaphil cleanser to wash face, SF gel 1% to teeth and Chlohexidine 0.12% mouth wash. Staff was not observed to provide client #2 with information regarding the names, purpose and possible side effects of his medications. 5. Observations conducted on 4/18/19 at 7:55 AM revealed client #4 was prompted by staff to enter the medication administration area where she was assisted by staff to receive medications including stool softener 100 mg., fish oil 1000 mg., Fluoxetine 20 mg., Loxapine 10 mg., and One-A-Day Women's vitamin-one tablet by mouth as well as topical medications including Gentle Cleanser to face and fingernails and Chlorhexidine 0.12% mouthwash. Staff was not observed to provide client #4 with information regarding the names, purpose and possible side effects of her medications. Interview conducted with the qualified intellectual disabilities professional (QIDP) on 4/18/19 revealed all clients should receive information regarding the names, purpose and possible side effects of their medication during each medication administration opportunity. B. Observations conducted throughout the 4/17/19 - 4/18/19 survey revealed client #4 to have dark blue bruising on her face from the mid-cheek area bilaterally, around both eyes and across her forehead. Review of facility incident reports for client #4 revealed a report dated 4/15/19 documenting	W 331	A nursing training session will be conducted on an annual basis with all staff. The training will include the requirement during each medication administration all clients will take an active part; to the extent possible, and will be asked the name, purpose and possible side effects of each medication. This training will be verified by the QIDP with a siginature sheet and date of participation by each staff member. 6/17/19	

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W 331	Continued From page 8 client #4 fell in the group home at 8:00 AM. Continued review of the 4/15/19 incident report for client #4 revealed a nurse's notation documenting "client fell this AM - fell on face and forehead. Left eye black/blue and completely swollen shut. Scratches to bilateral knees. Ice to left eye. She can move all extremities, cannot see out of left eye. Talking her usual verbage. Appears WNL". Further review of the 4/15/19 incident report for client #4 revealed no documentation related to notification of the physician and no follow up monitoring by nursing related to the head injury. Review of the record for client #4 on 4/18/19 revealed no documentation related to the incident/fall on 4/15/19. Interview conducted on 4/18/19 with the QIDP verified no documentation was available in client #4's record related to the fall on 4/15/19, and further verified the physician had not been notified of this fall/injury.	W 331	The facility Nurse will create criteria for concussion protocol. This protocol will be reviewed and approved by the facility Doctor. A form for documenting any incidents that involve a direct blow to the head of any of the clients will be created by the QIDP to include the approved concussion protocol. This form will be reviewed and updated as needed on an annual basis by the QIDP.	6/17/19
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility's system for drug administration failed to assure all drugs were administered without error for 1 of 5 clients observed during drug administration (#5). The finding is:	W 369		

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W 369	Continued From page 9 Observations conducted on 4/18/19 at 7:35 AM revealed client #5 was prompted by staff to enter the medication administration area where she was assisted by staff to receive medications including Aripiprazole 10 mg.-one tablet, Centrum Silver-one tablet, Lisinopril 20 mg.-1 and 1/2 tablets, Potassium ER 10 meq -one tablet, Venlafaxine ER 150 mg.- one tablet, Metformin XR 500 mg. -one tablet and Vascepa 1 GM-one tablet. Review of the record for client #5, conducted on 4/18/19 revealed physician's orders dated 3/19/18 revealed client #5 should receive Metformin XR 500 mg.-two tablets by mouth twice daily. Continued review or the record for client #5 revealed a physician's order dated 4/4/19 revealed client #5 should receive Vascepa 1 GM -two tablets twice daily. Interview conducted with the qualified intellectual disabilities professional (QIDP) on 4/18/19 verified client #5 should have received Metformin XR 500 mg.-two tablets by mouth during the morning medication administration on 4/18/19 as ordered by the physician. Continued interview with the QIDP further verified client #5 should have received Vascepa 1 GM-two tablets by mouth during the morning medication administration on 4/18/19 as ordered by the physician.	W 369	The facility Nurse will have a annual training session with all staff members on medication administration procedures. This training will have a signature sheet to verify completion by all staff. The completion of this requirement will be monitored by the QIDP. 6/17/19	
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions.	W 441		

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W 441	Continued From page 10 This STANDARD is not met as evidenced by: Based on review of facility records and staff interviews, the facility failed to hold evacuation drills under varied conditions during first and third shifts. The finding is: Review of the facility's fire evacuation drills conducted during the past survey year revealed first shift evacuation drills were conducted on 5/21/18 at 7:15 AM; 9/2/18 at 10:00 AM; 12/8/18 at 10:00 AM and 2/2/19 at 9:58 AM. Continued review of the facility's evacuation drills revealed third shift fire evacuation drills were conducted on 4/4/18 at 10:15 PM; 7/5/18 at 10:15 PM; 10/5/18 at 10:15 PM; 1/10/19 at 10:10 PM and 4/14/19 at 10:05 PM. Interview conducted with the qualified intellectual disabilities professional on 4/18/19 verified first shift fire drills were usually conducted at or around 10:00 AM during the past survey year, and further verified third shift evacuation drills were usually conducted at or around 10:00 PM during the past survey year. Therefore, the facility failed to hold evacuation drills under varied conditions as required.	W 441	The fire drill schedule will be amended to comply with the requirement of having a 3rd shift drill at various times of the night and not just at the start of the shift. This schedule change will be implemented by the QIDP and will be reviewed annually. 6/17/19	