STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G133	A. BUILDING ______ B. WING ______	06/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST BEND GROUP HOME	47 S OAK STREET BREVARD, NC 28712

(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 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(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:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: The facility failed to assure the emergency plan (EP) created to address potential emergency events and hazards was developed specific to the needs of the group home as evidenced by interview and record verification. The finding is: Review on 6/17/19 of the facility's EP dated	E 006	An emergency plan was developed specifically for the needs of the Forest Bend Group Home and includes information specific to the group home. The safety chairperson will train all staff on the new plan. The Emergency Plans will be monitored during monthly Environmental Assessments completed by the clinical team to ensure they are updated and in place at the group homes. In the future the Administrator will ensure the Emergency plans are updated and reviewed annually and staff are trained initially when hired and then periodically to ensure the plans are able to be carried out. RECEIVED JUL - 3 2019 DHSR NH L & C Black Mountain / WRO	8-18-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Carithers | TITLE: Administrator | (X6) DATE: 7/1/19

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 006	Continued From page 1 5/2019 at the administrative office revealed it to contain plans for potential emergency events and hazards that might occur at the group home including fire, flood, extreme weather and utility failure among others. Review of each of these event plans revealed a general approach to each that was not specific to the group home. Further review of event plans revealed them to contain information that was not accurate to the facility such as contacting the "LA County DPH Health Facilities Inspection Division" and the "California Governor's Office." Interview with the facility administrator and the facility trainer revealed the facility EP was handed down from the larger agency that runs the group home. Further interviews revealed the EP should have been modified to be specific to the group home instead of the generic and inaccurate information provided in the current plan. In addition, review of the facility's EP located at the group home on 6/17/19 revealed the plan was dated 12/2017 and was modified to contain more specific information regarding the group home. However, further review of the EP revealed that much of the information was old and outdated regarding responsible staff and emergency numbers.	E 006		
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,	E 007		

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OMB NO. 0938-0391

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E 007	Continued From page 2 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: The facility failed to assure the emergency plan (EP) contained information specific to the needs of clients in the group home as evidenced by interview and record verification. The finding is: Review of the facility EP on 6/17/19 revealed the plan to simply contain a copy of each client's person centered plan (PCP). Further review of the EP revealed that although the clients' PCPs contained the needed information about each client, it did not contain important information about each client in a manner that was easy for people who may have to work with the clients and not be familiar with them. Interview with the facility administrator and trainer revealed an understanding of the need to change the format to be more user friendly but as of the 6/17-18/19 survey that had not been completed. In addition, review of the EP located at the group home revealed only old outdated PCPs were included as part of the plan.	E 007	Updated face sheets were developed for each resident of the home and included in the emergency plan. These face sheets are shortened versions of the PCP and include quick reference information for use when familiar and non-familiar staff are dealing with the residents. The QIDP will train staff on the new face sheets and how to use them. The clinical team will monitor during Environmental Assessments to ensure face sheets for people supported are in the Emergency Plans and are current. In the future the administrator will ensure all staff are trained on Emergency Plans.	8-18-19
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is	E 036		

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E 036	Continued From page 3 based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: The facility failed to ensure a system was in place to assure staff were adequately trained on the emergency plan (EP) as evidenced by interview and record verification. The finding is:	E 036	The Home Manager or QIDP will ensure staff are trained on the use of the Emergency Plan for the group home when they are hired and then annually to ensure they are knowledgeable regarding the implementation of the plan. The Administrator will monitor new hire training in-services to ensure training occurs. In the future the Administrator will ensure all staff are trained on Emergency Plans.	8-18-19

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E 036	Continued From page 4 Review of the facility EP on 6/17/19 revealed no information regarding staff training was included in the plan. Interview with the facility administrator and trainer revealed the instructions from management only included the need to ensure staff were trained on how to use the EP manual and not training staff on specific parts of the EP. Further interview with the trainer and facility administrator revealed there is currently no system to train new staff on the EP or assure current staff are trained annually on the information contained in the EP.	E 036		
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	Cross Reference E006	8-18-19

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E 039	Continued From page 5	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 interview and record verification the facility failed to assure exercises were conducted annually to test the facility emergency plan (EP) as required. The finding is:

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E 039	Continued From page 6 Review of the facility EP on 6/17/19 revealed no information was included in the plan regarding testing the facility's EP or any summaries of actual emergencies occurring within the past year. Interview with the facility administrator and trainer revealed no testing either actual or table top exercises have occurred during the past year. Further interviews revealed the facility has no system in place to assure testing of the EP occurs as required.	E 039		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, interviews and record review the facility failed to ensure the Person Centered Plan (PCP) for 1 of 5 sampled clients (#1) included objective training to meet the client's needs relative to daily living skills. The finding is: Morning observation in the group home on 6/18/19 at 6:40 AM revealed client #1 to come out of his room and pace about the group home between the kitchen area, bedroom and living room. Further observations at 7:00 AM revealed the home manager in the kitchen preparing breakfast consisting of scrambled eggs and biscuits. The home manager was noted to prompt client #1 to assist with setting the table with placemats and napkins. After completing the	W 227	The Habilitation Specialist will review the ABI for all residents of the group home to determine if their objectives for daily living skills are adequate for their needs. A team meeting will be held to discuss client #1's training needs. The Habilitation Specialist will in-service staff on the results of the team meeting. The QIDP will revise the Person Centered Plan to include the team meetings. The clinical team will monitor through observations and Interaction Assessments 2 times a week for a period of one month then, on a routine basis to ensure staff are implementing all client programs as prescribed. In the future the QIDP will ensure Person Centered Plans contains objectives to meet identified needs of clients.	8-18-19

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W 227	Continued From page 7	W 227		

task, client #1 was observed to continue with pacing around the group home. Client #1 was observed to eat breakfast between 7:30 AM - 7:50 AM. Observation at 7:50 AM revealed the client took his dishes to the kitchen then returned to his room. Continued observation revealed Staff A assisted client #1 with shaving and brushing his teeth before client #1 continued pacing the group home. Staff A was then noted to prepare mop water and begin mopping client #1's floor without client #1's assistance.

Interviews with Staff A and the facility home manager (HM) revealed client #1 usually participates less in the morning than in the afternoon because he isn't a morning person. Further interview with Staff A and the HM revealed client #1 is capable of doing chores and activities but requires more prompting especially in the morning.

Record review, substantiated by interview with the home manager, revealed client #1 currently does not have many objectives to work on. Review of client #1's PCP dated 8/15/18 revealed the client had four objectives trained in the home including using napkins, using the dishwasher, signing, and laundry. Further review of the PCP revealed an adaptive behavior inventory (ABI) dated 4/19/19 which noted client #1 has no independence in all areas of meal preparation such as setting or clearing the table or working in the kitchen. In addition, client #1 has no independence in housekeeping such as emptying the trash, making his bed and sweeping the floors. Continued review of the PCP, substantiated by interview with the home manager, revealed client #1 does not have objective training to meet his meal prep or household chore needs.

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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: The facility failed to assure the behavior support plan (BSP) for 1 of 5 sampled clients (#5) was implemented as prescribed to support achievement of the objective as evidenced by observation, interview and record verification. The finding is: Morning observations in the group home on 6/18/19 revealed client #5 finishing his breakfast at 7:50 AM and begin to gesture to staff his desire for more food. The client was observed to attempt to hand his plate to the home manager, tap the home manager on the shoulder and point to the kitchen becoming more animated each time. Further observations revealed the home manager to assist client #5 with getting more scrambled eggs but when the client gestured for another biscuit the home manager told him that he could not have seconds on that. The client attempted for another minute to get the home manager to give him another biscuit before returning to the table and turning his attention to Staff A. Continued observation at 7:55 AM revealed client #5 to again tap and gesture excitedly to Staff A wanting another biscuit. Staff	W 249	The Behavior Specialist will in-service staff on Client #5's behavior support plan objectives. The clinical team will monitor through Interaction Assessments 2 times per week for one month and then on a routine basis to ensure staff are implementing client #5 BSP as prescribed and encouraging independence. In the future, QIDP will ensure each person receives a continuous active treatment program consisting of needed interventions and services as outlined in the Person Centered Plan.	8-18-19

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 249	Continued From page 9 A was observed after a couple of minutes of gesturing from client #5 to go to the kitchen with client #5 to get another biscuit. Interview with the home manager, substantiated by review of client #5's physician's orders dated 4/10/19, revealed client #5 is currently on a diabetic diet and should not be getting additional bread at meals. Further interview with the home manager revealed Staff A gave client #5 the biscuit to keep him from having a behavior. Review of client #5's person centered plan (PCP) dated 8/14/18 revealed a BSP dated 7/1/18 to address the clients target behaviors of mishandling property, SIB, inappropriate toileting, inappropriate sexual behavior, tantrums and disrupted sleep. Review of the BSP revealed client #5's tantrums are identified as signs of frustration which may include increased vocalizations, increased activity and can escalate to attempts to harm others through scratching, hitting, kicking and pushing. Further review of the BSP revealed the client "enjoys having things his way and can be resistant to staff initiated changes." Continued review of the BSP revealed staff should prompt client #5 to calm, be able to meet his need if appropriate or offer an alternative activity. Subsequent review of the BSP revealed no direction for staff to give in to client #5's demands to prevent behaviors from occurring.	W 249		