STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G107	A. BUILDING _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEK ROAD GROUP HOME	138 MEEK ROAD GASTONIA, NC 28056

(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 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 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.	E 039	The Meek Road ICF-IID Home will conduct an All Hazards individual facility based exercise twice yearly. Each participant will be asked to sign once the shelter in place and evacuation drills are completed. When GRS first completed their Emergency Plan, both individual facility exercises and tabletop exercises were completed. As the best practices changed for practicing full drills, GRS moved to 2 All Hazard drills. It is unclear regarding why the Meek QIDP did not present the two drills and all staff who participated. The July drill is due, so it will be completed immediately and the December drill will be held as scheduled. Both the staff training sign in and the staff participation sign in will be kept in the facility's All Hazards Plan in its own section. The House Manager and/or QIDP are responsible for assuring both exercises are completed and the signed forms entered into the All Hazards plan. These drills will also be reported to GRS' Safety Committee for review and sign off. RECEIVED JUL 25 2019 DHSR NH L & C Black Mountain / WRO	9.7.19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonda S. Stillwell — TITLE: Assistant Director — (X6) DATE: 7.22.19

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 039	Continued From page 1 *[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 record review and interview, the facility failed to assure exercises were conducted annually to test the facility's emergency plan (EP) as required. The finding is: Review of the facility's EP, conducted on 7/8/19, revealed staff were provided with instruction related to the facility's EP during a staff meeting on 12/5/18, however, no documentation was available indicating any testing or table-top exercises were conducted during the past year. Interview with the facility qualified intellectual disabilities professional revealed no system was in place to assure testing of the facility's EP, and further verified no drill had been conducted during the past year to test the facility's emergency plan as required.	E 039	*** see page 1	9.7.19
W 104	GOVERNING BODY CFR(s): 483.410(a)(1)	W 104		

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W 104	Continued From page 2 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to exercise general policy, budget, and operating direction over the facility by failing to maintain bedroom furnishings for 1 of 3 sampled clients (#1). The finding is: Observations conducted throughout the 7/8/19 - 7/9/19 survey revealed a chest of drawers present in client #1's bedroom was missing all six drawers. Further observations of client #1's bedroom revealed no window covering was present. Review of the record for client #1 revealed an Individual Program Plan (IPP) dated 6/5/19 which included a behavior support plan (BSP) dated 12/6/18 identifying property destruction as a targeted behavior. Continued review of the 6/5/19 IPP for client #1 revealed no restriction was included related to access to personal possessions. Interview conducted with the qualified intellectual disabilities professional (QIDP) on 7/9/19 verified all the drawers were missing from client #1's chest of drawers and further verified there was no covering on client #1's bedroom window. Continued interview with the QIDP revealed the window covering had been missing for several days due to client #1 pulling the covering off the window. This interview further revealed the drawers from client #1's dresser had been	W 104	All rooms at the Meek Road home will be reviewed to assure the facility exercises general policy, budget, and operating direction over the facility by maintain bedroom furnishings for all residents. Specifically, person served #1 will have a solution for keeping a dresser in his room that he does not break apart. The QIDP and Chief Operating Officer are responsible for assuring these items are available and in good, working order. Once repaired or replaced, the QIDP will, at least quarterly, report to the COO the condition of each rooms furniture and supplies to assure this does not reoccur.	9.7.19

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W 104	Continued From page 3 missing for more than two weeks due to his taking the drawers out and breaking them. This interview further revealed the facility would replace the items missing from client #1's bedroom, however, no date was available at this time as to when the items would be replaced.	W 104		