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	34G083	A. BUILDING _____ B. WING _____	09/04/2019

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BLANCHE DRIVE	6208 BLANCHE DRIVE RALEIGH, NC 27607

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E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [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:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical	E 020		

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 020	Continued From page 1	E 020		

Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.

* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.
This STANDARD is not met as evidenced by:
Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness, which included specific plans where to relocate the clients in the facility in case of an emergency evacuation. The finding is:

Management staff did not formulate an agreement with an outside entity regarding sheltering individuals and staff in the event evacuation of the facility became necessary.

Review on 9/3/19 of the facility's emergency preparedness plan dated 6/2019 did not include an agreement with alternate lodging specific to where the clients would evacuate in the event of an emergency

Interviews on 9/3/19 with the qualified intellectual disabilities professional (QIDP) revealed the emergency preparedness plan (EP) was a template to be used as a guide in developing the facility's EP. When asked where clients would be relocated, the qualified intellectual disabilities professional (QIDP) stated a local entity would be used. He stated there was no written agreement or contact person.

During an interview on 9/3/19, the QIDP acknowledged the plan does not include all of the

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E 020	Continued From page 2 components outlined in the emergency preparedness plan including an agreement with a local entity that may be used for lodging should the clients need to evacuate from the facility.	E 020		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to assure direct care staff demonstrated the skills and techniques to address the health needs of 1 of 3 audit clients (#3) in the facility. The finding is: Staff failed to demonstrate the skills needed to monitor blood pressures. During observations of the medication administration pass on 9/4/19 at 7:04am, staff began by taking client #3's blood pressure. After reading the blood pressure staff told the surveyor the systolic pressure was 92 and the diastolic pressure was 68. When staff was asked what parameters the Nurse had instructed staff to be aware of and when she wanted to be notified, staff stated, "Yes." When asked again, staff could not articulate the parameters of low and high blood pressures when they were to contact the Nurse. Review on 9/4/19 of client #3's record revealed she is prescribed Levothyroxine .5mcg by mouth every am. Review of the medication	W 192		

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W 192	Continued From page 3 administration record (MAR) revealed staff are to take client #3's blood pressure every am before administering her medication. Further review of the MAR revealed staff were to notify the Nurse if client #3's systolic pressure is below 80. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed staff should be familiar with blood pressure parameters and when the Facility Nurse is to be contacted.	W 192		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the individual program plan (IPP) was reviewed and revised as necessary. This affected 1 of 3 audit clients (#1). The finding is: Client #1's team failed to revise her behavior support program (BSP). Review on 9/4/19 of client #1's individual program plan (IPP) dated 6/18/19 revealed she has target behaviors of self-injurious behaviors, inappropriate verbalizations and physical aggression. Further review of client #1's individual program plan (IPP) dated 6/18/19	W 257		

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W 257	Continued From page 4 revealed a BSP dated 6/13/18 to address these target behaviors. Review of her behavioral data for the past 6 months indicated that client #1 had not exhibited any episodes of physical aggression. Review on 9/4/919 of a note by the qualified intellectual disabilities professional (QIDP) for client #1's progress summaries dated 7/2019 revealed a note indicating that client #1's BSP needed to be revised. Interview on 9/4/19 with the QIDP confirmed there has been no episodes of physical aggression by client #1 in several months. Further interview revealed he has contacted the Psychologist several times to to request revisions to client #1's BSP, however this has not been completed.	W 257		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior support plan (BSP) for 1 of 3 audit clients (#5) was reviewed and monitored by the human rights committee (HRC). The finding is: Management staff failed to have the human rights committee review a restrictive behavior plan for	W 262		

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W 262	Continued From page 5 client #5. Review on 9/4/19 of client #5's behavior support program (BSP) dated 9/26/17 revealed this program addresses the following target behaviors: non-compliance, physical aggression and inappropriate verbalizations. Further review revealed this program incorporates the use of Paroxetine 20 mg., Alprazolam 2 mg. (for physician appointments) and Abilify 2 mg daily and the use of a crisis dose of Abilify 2 mg. for agitation. Additional review of this program revealed the guardian signed written informed consent on 10/8/18. There was no written consent from the HRC for the BSP in client#5's BSP. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed the HRC is mandated to review any programs that contain restrictions, including the use of psychotropic medications. Further interview confirmed there was not consent from the HRC for client #5's BSP dated 9/26/17.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and verified by interview, the facility failed to assure the behavior support plan (BSP) for 1 of 3 sampled clients (#1) was conducted only with the written informed consent	W 263		

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W 263	Continued From page 6 of the guardian. The finding is: Client #1's interdisciplinary team failed to obtain written informed consent for her BSP. Review on 9/4/19 of client #1's record revealed she has been adjudicated incompetent and appointed a Guardian of the Person to act on her behalf. Review of the IPP revealed client #1 has target behaviors of self-injurious behaviors, inappropriate verbalizations and physical aggression. Further review of client #1's individual program plan (IPP) dated 6/18/19 revealed a BSP dated 6/13/18 to address these target behaviors. Further review of the BSP revealed no written informed consent from client #1's legal guardian. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed that all behavior support programs (BSP)'s that incorporate restrictions which include the use of psychotropic medications must have written informed consent from the legal guardian for the person they support. Additional interview confirmed he had obtained verbal consent for client #1's BSP dated 6/13/18 but that he had not followed up with the legal guardian to obtain written informed consent.	W 263		
W 316	DRUG USAGE CFR(s): 483.450(e)(4)(ii) Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: The facility failed to show evidence medication to	W 316		

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W 316	Continued From page 7 control inappropriate behaviors for 1 of 3 sampled clients (#5) had attempted to be reduced within the year or documentation showing the client is on the lowest effective dosage as evidenced by interview and review of records. The finding is: Client #5's team failed to review the use of her crisis medication to determine if it was still needed. Review on 9/4/19 of client #5's behavior support program (BSP) dated 9/26/17 revealed this program was to target the inappropriate behaviors of Non-Compliance, Physical Aggression and Inappropriate verbalizations. The program included the use of psychotropic medications to include Abilify 2 mg. daily, Paroxetine 20mg. and Alprazolam 2 mg. The program also included a crisis dose of Abilify 2mg. as needed anxiety and agitation. Review on 9/4/19 of client #5's recent physician orders dated 6/26/19 revealed no recent use of this crisis dose of Abilify 2mg. as needed anxiety and agitation. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) revealed client #5 has not required the use of the crisis dose of Abilify 2mg. in over 6 months. Further interview confirmed the team has not discussed with the Physician the continued need for this crisis dose of Abilify 2mg. for client #5.	W 316		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are	W 369		

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W 369	Continued From page 8 self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations and confirmed with record reviews and interviews, the facility failed to assure all medications were given as ordered. This affected 1 of 3 audit clients (#3) residing in the facility. The finding is: Staff failed to ensure audit client #3 received Azelastine Nasal spray as ordered by the physician. During observations on 9/4/19 of the medication administration pass for client #3 at 7:04am, staff administered the following: Desmopressin tablets (4) , Boost HC (1), Lactulose 15ml., Levetiracetam 500 mg. (2), Levothyroxine .5 mcg. (1), Vitamin D3 2,000 units (1) and Azelastine nasal spray 0.1% (1) spray for each nostril. Review on 9/4/19 of the physician order for client #3 dated 6/26/19 revealed the following: Desmopressin tablets (4) , Boost HC (1), Lactulose 15ml., Levetiracetam 500 mg. (2), Levothyroxine .5 mcg.(1), Vitamin D3 2,000 units (1) and Azelastine nasal spray 0.1% (2) sprays for each nostril. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) revealed client #3's physician orders are current and should have been followed to assure that client #3 was given Azelastine nasal spray 0.1% (2) sprays for each nostril.	W 369		