STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G305	A. BLDG. _____ B. WING _____	06/04/2019

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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 6/3/19 and 6/4/19 of the facility's EPP titled "Brookwood Emergency Management Plan Brookwood Residential Program" and updated 5/25/18 revealed no client specific information pertaining to adaptive equipment and behavior support plans (BSPs) were included in the plan. Further review of the EPP and verified on 6/4/19 by interview with the qualified intellectual disabilities professional (QIDP) revealed the facility had not included specific information in the EPP pertaining to client needs and behavioral information 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, developmental needs, behavioral needs, adaptive equipment, mode of communication and medical supports to promote safety and the provision of optimal care during an actual emergency. A clinical meeting will be scheduled by the QIDP; and updates to the EPP will take place to address specific client information, affecting 6/6 clients in the home. The QIDP will provide in-service training on the updated EPP to all applicable staff in the home. The ICF Director and/or QA will review the EPP monthly for updates to ensure continued compliance. RECEIVED JUN 28 2019 DHSR NH L & C Black Mountain / WRO	8/3/19 8/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Jacobs, COO/Administrator — TITLE: — (X6) DATE: 6/26/19

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 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		

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E 020	Continued From page 2 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 interview, the facility failed to assure the policies and procedures included accurate information for the safe evacuation from the facility to the identified evacuation site location(s). The finding is: Review of the emergency preparedness plan (EPP) on 6/3/19 titled "Brookwood Emergency Management Plan Brookwood Residential Program" and updated 5/25/18, revealed a local and out of the county evacuation site information for the group home should an off site location be needed. Continued review of the EPP identified the group home's local evacuation site to be a school located in town. Further review of the EPP identified the group home's out of county evacuation site to be the day program located in a neighboring city. Interview with the qualified intellectual disability professional (QIDP) on 6/4/19 confirmed the EPP did not accurately identify the out of county evacuation site because the facility's day program has since relocated. Further interview confirmed the address noted in the EPP was the old address and was not up to date.	E 020	The facility will ensure that the Emergency Preparedness Plan (EPP) is updated to include accurate information for the safe evacuation of clients in the event of an emergency. The QIDP will update the EPP to include the new day program location as an alternative evacuation site in the event of an emergency. The QIDP will provide in-service training on the updated EPP to all applicable staff in the home. The ICF Director and/or QA will review the EPP monthly for updates to ensure continued compliance.	8/3/19 8/3/19
E 037	EP Training Program CFR(s): 483.475(d)(1)	E 037		

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E 037	Continued From page 3 (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 4 least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The	E 037		

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E 037	Continued From page 5 CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency	E 037		

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E 037	Continued From page 6 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on review of the facility's training program relative to the emergency preparedness plan (EPP) and interviews, the facility failed to provide EPP training for staff at least annually. The finding is: Review on 6/3/19 of the facility's most recent EPP manual titled "Brookwood Emergency Management Plan Brookwood Residential Program" and updated 5/25/18 revealed no documentation of a tabletop drill for staff training. Continued review of the 5/25/18 EPP revealed no documentation of any staff training related to the EPP. Interviews conducted on 6/3/19 and 6/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed there is no EPP staff training documentation.	E 037	The facility will ensure that all staff in the home receive initial and annual training on the Emergency Preparedness Plan (EPP) and any updates thereafter to address their competencies in its implementation. Training will include but not limited to resource contacts, client specific competencies and implementation of a tabletop exercise to reflect an actual evacuation. The QP will provide initial, updates and annual staff training on the EPP to increase staff knowledge and competencies in the event of an actual emergency. The QIDP will schedule a training session for all staff on the EPP. The QIDP will secure staff in-service sheets and maintain on file to reflect staff training on the EPP as required. The ICF Director and/or QA will monitor staff training records on the EPP on a quarterly basis to ensure continued compliance.	8/3/19 8/3/19
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	Continued From page 7 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide staff training that enables direct care staff (DCS) to perform their duties effectively and efficiently related to client program implementation for 1 of 3 sampled clients (#6). The finding is: Morning observations in the group home on 6/4/19 at 7:10 AM revealed staff I to verbally prompt various clients to the kitchen for lunch meal preparations. Continued observations revealed staff I to verbally prompt various clients to the kitchen to assist with blending client lunch foods in the home's food processor. Further observations during this time revealed client #6 to sit in the living room unengaged. Review on 6/3/19 of client #6's treatment/habilitation/support activity plan dated 5/29/19 revealed her programs include a toothbrushing routine, place setting, sensory object manipulation, exercise once daily, and puree her food for 10 seconds once a day. Interview on 6/4/19 with staff I at 8:00 AM about why client #6 was not verbally prompted to blend her food revealed client #6 only has a toothbrushing program on 1st shift. Continued interview revealed client #6's other programs of using a sensory object and performing exercise walks are conducted on 2nd shift. Further interview revealed client #6 will not blend her food. Subsequent interview on 6/4/19 at 8:17 AM with staff I regarding client #6's toothbrushing and sensory object program objectives and steps, revealed she is unsure of how to reference client #6's program goals in the program book. In	W 189	The facility will ensure that staff receive training and demonstrate competencies to implement training programs, and/or strategies and interventions in accordance with the Individual Support Plans for all clients in the home. For Client #6 the home manager and QIDP will in-service all staff on current program objectives. In addition, the team may consider new training upon review of the ABI and assessment tools as applicable. The QIDP will in-service all staff on any updated training as well. In addition, the QIDP will facilitate a team meeting to review training programs for all other clients in the home. The team will determine updates to programs when applicable. The QIDP will in-service all staff in the home on 6/6 clients' program training. The QIDP will conduct weekly observations during the morning and evening routine in the home of staff competencies on client programs to ensure continued compliance.	8/3/19 8/3/19 8/3/19

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W 189	Continued From page 8 addition, staff I confirmed she has not received sufficient training pertaining to clients' program objectives and goals. Interview on 6/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed DCS may need additional training on client objectives and goals.	W 189	The facility will ensure that all program objectives developed and implemented address priority client needs as support by the comprehensive functional assessment (CFA).	8/3/19
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, record review and interview, the facility failed to assure the treatment/habilitation/support service activity plan for 1 of 3 sampled clients (#2) included objective training to meet the client's identified needs in the areas of pro-social behaviors, pre-vocational/vocational, pre-reading/reading and work-related behaviors. The finding is: Throughout the 6/3/19 to 6/4/19 survey period in the group home revealed client #2 to consistently occupy a seat in the same area of the home's living room couch. Continued observations revealed client #2 to consistently verbalize episodes of instructive language to her peers. Record review on 6/4/19 of client #2's treatment/habilitation/support service activity plan dated 4/2/19 revealed formal goals to purchase	W 227	For Client #2 the QIDP will schedule and facilitate a team meeting to review the ABI, BSP and other evaluations to determine more appropriate training in accordance with the client's priority needs. As a result, the team will consider new training as applicable. The QIDP will in-service all staff on any updated training for Client #2. The QIDP will facilitate a team meeting to review the CFA and training programs for all other cleints in the home. The team will determine updates to programs when applicable. The QIDP will in-service all staff in the home on 6/6 clients' program training as applicable. QA and/or ICF Director will conduct monthly reviews of client records to ensure continued compliance.	8/3/19 8/3/19

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W 227	Continued From page 9 item, place clothes in washer, attend to a task for 10-15 minutes, floss teeth, prepare simple vegetable, put dishes in dishwasher and independently play card games with peers daily Monday through Friday for 20 minutes. Ongoing review on 6/4/19 of client #2's hab/support/plan revealed a behavioral support plan (BSP) dated 4/3/19 with an objective to decrease episodes of disruptive or maladaptive behavior in which one or more target behaviors is displayed no more than 13 episodes per month for 6 consecutive months. Continued review of client #2's BSP revealed target disruptive/maladaptive behaviors include property destruction/misuse, physical and verbal aggression, inappropriate language, self-injurious behavior (SIB), and noncompliance/resistance. Further review on 6/4/19 of client #2's hab/support/plan revealed an adaptive behavior inventory (ABI) last updated 3/25/19. Subsequent review of client #2's ABI revealed the following needs: improve pro-social behaviors, attend to task for a minimum of 15 minutes/30 minutes/60 minutes, listen to presentation for 15 minutes/30 minutes, able to read sight words, able to read on a 2nd/3rd grade level, and cooperative/productive work-related behaviors. Interviews on 6/4/19 with the qualified intellectual disabilities professional (QIDP) verified client #2 could benefit from additional formal objectives both in the group home and at the day program.	W 227		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for	W 288		

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W 288	Continued From page 10 an active treatment program. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure techniques to manage the behavior of 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6) were not used as a substitute for active treatment. The finding is: Morning observations in the group home on 6/4/19 at 8:10 AM revealed client #3 to brush her teeth in the bathroom accompanied by staff member L. Continued observations revealed when client #3 completed her toothbrushing routine, staff L then verbally prompted client #3 to return her toothbrush and toothpaste to her personal hygiene basket. Further observations revealed client #3 to comply with staff L's directive, to quickly exit the bathroom and to then enter a storage closet room within the group home's laundry room area. Subsequent observations revealed client #3 to place her toothbrush and toothpaste in her personal hygiene basket located in a large bookshelf storage unit contained within the group home's laundry room area. Ongoing observations revealed all of the other client's personal hygiene baskets (#1, #2, #4, #5, and #6) to also be located in close proximity in the same large bookshelf storage unit. In addition, observations revealed the door to the storage closet room to have an operable locking mechanism and household cleaning solution containers were visibly located on the floor underneath this same large bookshelf storage unit. Immediate interview with staff L on 6/4/19 at 8:15 AM revealed clients personal hygiene baskets are	W 288	The facility will ensure that such techniques designed to manage client behaviors are discontinued and therefore not used in the future unless incorporated into an active treatment program. For all cleints in the home the QIDP will schedule a team meeting to review the restricted access to clients' personal hygiene baskets. This practice will be discontinued as a blanket restriction. Should a client display behavior that impact health and safety, then the team will assess and incorporate any restricted access in an active treatment program for the specific client -based on needs and risks. The QIDP and home manager will provide staff in-service on all clients' right to access personal hygiene basket unless incorporated into an active treatment program. The QIDP and/ home manager. will conduct weekly observations in the home to ensure continued compliance.	8/3/19 8/3/19 8/3/19

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W 288	Continued From page 11 "kept in this laundry closet to keep clients from messing with them." In addition, interview with staff I on 6/4/19 at 8:30 AM regarding clients personal hygiene baskets revealed "They're all kept locked in the closet." Interview with the qualified intellectual disabilities professional (QIDP) on 6/4/19 revealed none of the 6 clients residing in the group home have behaviors of misusing any of their personal toiletries or grooming supplies and no client has any stated restrictions in their treatment/habilitation/support service activity plans. Continued interview with the QIDP confirmed clients should have unrestricted access to their personal hygiene/ grooming supplies, and further verified the personal grooming/toiletry supplies for all 6 clients should be kept in their personal bedrooms.	W 288	The facility will implement a system to ensure that evacuation drills are conducted at varied times and conditions to include 1st, 2nd and 3rd shifts respectively. The QIDP and home manager will develop a schedule for staff in the home to implement evacuation drills that are reflective of varied times and conditions with emphasis on all three (3) shifts.	8/3/19
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Review of fire drill reports on 6/3/19 revealed the following: For 1st shift, 4 fire drills occurred at 7:15 AM, 7:30 AM, 7:32 AM, and 7:36 AM. Continued review revealed for 2nd shift, 2 fire drills occurred at 7:23 PM, 7:29 PM, and 2 occurred at 4:30 PM. Further review revealed for 3rd shift, 2 fire drills occurred at 11:15 PM, 11:32 PM, and 2 occurred at 11:30 PM.	W 441	The QP will in-service all staff on the update evacuation schedule with a specific emphasis on all shifts. The QIDP and home manager will monitor the evacuation drills on a monthly basis to ensure continuous compliance.	8/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G305	A. BLDG. _____ B. WING _____	06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298

(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
W 441	Continued From page 12 Interview on 6/3/19 and 6/4/19 with the qualified intellectual disabilities professional (QIDP) revealed the following staff shift times and staffing numbers: For 1st shift, 2 staff work 7:30 AM to 3:30 PM. Continued interview revealed for 2nd shift, 3 staff work 3:00 PM to 11:00 PM with modified shift times Monday through Friday. Further interview revealed for 3rd shift, 2 staff work 11:00 PM to 8 AM Monday through Friday and staff work 12-hour shifts on Saturday-Sunday. Subsequent interview with the QIDP confirmed fire drills were not conducted at varied times.	W 441	The facility will ensure that cold foods packed for lunch are always maintained at safe food temperatures using a cooling device The Home manager and QIDP will assess the availability of ice packs or other such cooling devices to determine the quantity and location in the home. Staff will always be advised to use the ice packs to place in the cooler when transporting client lunches. The QIDP and home manager will provide in-service training to staff in the home and the day program on the location and use of ice packs to maintain cold foods at safe temperatures for consumption. The QIDP, Day Program Director and/or Home Manager will inspect the cooler and monitor at the day program and home daily to ensure continued compliance.	8/3/19 8/3/19 8/3/19
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure the cold foods in the client's lunch bags were maintained at the proper state requirements for safe food temperatures for the client's residing in the home. The finding is: Morning observations in the group home on 6/4/19 at 8:35 AM revealed clients to load into the van. Continued observations at 8:40 AM of the van loading process and the contents contained within the van revealed a cooler. Further observations of the cooler revealed no cooling device(s) to be packed in the cooler. Subsequent observations revealed no cooling device(s) to be packed within clients individual lunch bags. Immediate interview on 6/4/19 at 8:45 AM at the	W 473		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G305	A. BUILDING _____ B. WING _____	06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298

(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
W 473	Continued From page 13 group home with the day program manager revealed individual client lunch bags consisted of Beefaroni, green string beans, 1 slice of bread, and a chocolate cookie. Continue interview confirmed ice packs were not packed in the individual lunch bags and ice packs should have been packed in the lunch bags to keep the food cold. Further interview revealed the drive to the day program requires at least 20 minutes. Interview on 6/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed ice packs should have been placed in each clients individual lunch bags to keep the food items cold while being transported to the day program.	W 473		