STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G057	A. BUILDING _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #3	401 WOODLAWN CIRCLE CLYDE, NC 28721

(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 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 every 2 years. 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.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC 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 record verification and interview, the facility failed to assure the emergency plan (EP) contained information specific to the needs of clients in the group home. The finding is: Review of the facility EP on 1/16/20 revealed the facility EP to reveal no specifics relative to any client of the group home. Further review of the EP revealed the plan to contain no information to support any client in a manner that was easy for	E 007	E007 The facility will add the client face sheets into the Safety Book in the facility. E007 The emergency plan (EP) will include provision that staff will take the facility laptop so that easy access to client-specific information may be accessed during an emergency. E007 The emergency plan (EP) will indicate the information that facility policy (#119) indicates that individual information sheets (client specific information) must be kept current and retained in agency vehicles. E007 The emergency plan (EP) will indicate the information that facility policy (#119) indicates that staff shall ensure that evacuated individuals are provided cover, safety, adequate food, and acceptable environmental temperatures. E007 Furthermore, the emergency plan (EP) will indicate the facility policy (#119) indicates that the Home Coordinator and/or the staff on duty will facilitate the evacuation steps of compiling the necessary emergency supplies (food, bedding, and clothing). Staff will transport individuals to the designated shelter along with the appropriate charts and medications (client-specific information) and will work with emergency personnel for them to safely transport individuals and staff. *Facility Policy #119 will be attached for reference. DHSR - Mental Health FEB 13 2020 Lic. & Cert. Section	2-14-2020 3-17-2020 3-17-2020 3-17-2020 3-17-2020

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 007	Continued From page 1 people who may have to work with the clients and not be familiar with them. Interview with the facility qualified intellectual disabilities professional verified client specific information such as communication needs, behavior plans, nutritional assessments or adaptive needs were not included in the current EP.	E 007	E007 Staff training shall occur: to review where client-specific information can be found in the event of an emergency or evacuation occurs; to include that client specific information that can and will be utilized during an emergency can be found in the company vehicle per Policy #119, review that in the event of an evacuation, Staff will take the laptop which will also provide access to needed client specific information that may be needed, to also review that emergency evacuation procedures, Policy #119 states that "staff will transport individuals to the designated shelter along with the appropriate charts (Medical Records) and medications"	2-5-2020 training for staff QP, Home Coordinator, and for the Group Home Supervisors. Anticipated date of completion: 3-2-2020 training for all other staff
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(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 every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015	E015 The emergency food supply inventory (Appendix 61-A) indicates the facility will maintain a supply of food and water to meet the needs of the group home for at least 3 days. The inventory provides a list of items and indicated quantity of items to assure subsistence needs of the group home. E015 Appendix 61-A indicates that the emergency food inventory and quantities be checked every 2 months and to be rotated every 6 months. Facility Policy (#119) and Appendix #61-A will be attached to the emergency food supply tote box and will be placed into the facility Safety Book. E015 Staff training will occur that reviews where the emergency food supply is located physically in the home. E015 Totes with rollers will be purchased/ implemented in the group home to store the emergency food/water supply and to ease the evacuation process.	2-14-2020 2-5-2020 and 3-2-2020 3-2-2020

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E 015	Continued From page 2 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on record verification and interview, the facility failed to assure the emergency plan (EP) contained information specific to the subsistence needs of the group home. The finding is: Observation of the the kitchen pantry of the group home on 1/16/20 revealed a plastic storage bin with various food items. Additional observation of the kitchen pantry revealed a storage of water on a shelf in the pantry. Review of the facility EP on 1/16/20 revealed no information relative to the subsistence needs of the group home. Interview with staff C on 1/16/20 revealed an emergency supply of food and water was kept in the kitchen pantry of the facility. Further interview with staff C revealed the staff	E 015	*Appendix 61-A will be attached as reference.	

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E 015	Continued From page 3 was unsure how long the supply of food and water was to sustain the facility during an emergency. Interview with the qualified intellectual disabilities professional (QIDP) verified emergency supplies were not addressed in the EP for the facility. Further interview with the QIDP confirmed the facility EP could benefit from additional specifics relative to emergency supplies such as specified items, location of items and details of delegated items such as the food and water supply.	E 015		
E 036	EP Training and Testing CFR(s): 483.475(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] 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 every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility 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,	E 036	E036 The facility Policy (#119) indicates that "Each year staff will receive training on Emergency and Evacuation procedures and renew annually" and that "staff will also receive training upon hire. Formal facility training regarding the emergency and evacuation plans and policy will be documented on the Emergency and Evacuation Policy Signature Sheet (Appendix 61) and/or staff meeting agendas, and/or on in-service training forms, and/or other staff training forms deemed appropriate by HR staff/Executive Director. E036 IN-Service training occurred 2-5-2020 with the Facility QIDP, the Home Coordinator, and the Group Home Supervisors to include the following inflormation: *Review of The Emergency Management Plan (EP); * training to addresses the Emergency Supplies/ Subsistence needs of the group home. (Also review Appendix #61-A Emergency Food Supply and Appendix #61-B Emergency/ Disaster Supply Inventory); training relative to specifics where the Emergency Supplies are located and information specific to details of the delegated emergency supplies.	Policy effective 10-04-04 and last revised 08/19 2-5-2020

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E 036	Continued From page 4 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 every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[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 evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on record verification and interview, the facility failed to ensure a system was in place to assure staff were adequately trained on the emergency plan (EP). The finding is: Review of the facility EP on 1/16/20 revealed no	E 036	E036 Continued: In-Service training occurred 2/5/2020 that reviewed: Appendix #61-A Emergency Food Supply and Appendix #61-B Emergency/Disaster Supply Inventory; Provided an in-service training of Emergency and Evacuation Policy #119; * reviewed where client-specific information can be found in the event of an emergency or evacuation occurs; Review/in-service occurred that client specific information that can and will be utilized during an emergency can be found in the company vehicle per Policy #119; * reviewed that In the event of an evacuation, Staff will take the laptop which will also provide access to needed client specific information that may be needed; * Reviewed also that per emergency evacuation procedures, Policy #119, page 3 of 6, step E :".....staff will transport individuals to the designated shelter along with the appropriate charts (Medical Records) and medications... E036 Additionally, the In-Service Training that was provided on 2-5-2020 to the QIDP, Home Coordinator, and to the Group Home Supervisors will also be provided to each Direct Support Professional Staff by the designated Group Home Coordinator/ Supervisor. E036 The In-Service Training Form will be placed into the safety book and a copy will go to HR for record-keeping. *Appendix 61-B will be attached as reference	3-2-2020 3-17-2020

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E 036	Continued From page 5 information regarding staff training was included in the plan. Interview with staff C on 1/16/20 revealed the staff had not been trained on the EP of the facility. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed the facility had no documentation of formal training to staff regarding the EP. Further interview with the QIDP 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		
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, review of records and interview, the team failed to ensure the individual habilitation plan (IHP) for 1 of 3 sampled clients (#4) included training to address needs relative to falling behavior. The finding is: Observation on 1/17/20 at 7:00 AM revealed 3 of 4 clients in the group home to be present in the facility. Interview with staff E on 1/17/20 revealed client #4 was not at the group home due to the need to go to the hospital after a fall during the night. Further interview with staff E revealed client #4 had a behavior with the third shift staff and hit her head in the bathroom. Interview with third shift staff, F, revealed about 2:45 AM on 1/17/20, client #4 became upset about the need	W 227	W227 The individual habilitation plan (IHP) for sampled client (#4) will include training to address needs relative to falling behavior. W227 The Interdisciplinary Team met on 2-3-2020 to discuss sampled client (#4) habilitation needs relative to falling behavior. W227 The individual habilitation plan (IHP) will be updated to reflect training to address needs relative to falling behavior and the sampled client (#4) will have a formal Behavior Support Plan developed to address training needs relative to falling behavior.	3-2-2020 2-3-2020 3-2-2020

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W 227	Continued From page 6 to get up to check her colostomy bag and after going into the bathroom the client fell face forward at the bathroom sink and hit her head. Staff F further revealed EMS was called and the client was transported to the hospital while the facility qualified intellectual disabilities professional met the client at the hospital. Interview with staff E and F revealed client #4 has a history of behavioral falls when the client becomes upset. Observation in the group home at 8:05 AM revealed client #4 to return to the group home with a swollen nasal area and stitches to the forehead. Review of incident reports for client #4 on 1/17/20 revealed from 8/2019 through the current survey date of 1/17/20, client #4 had 8 documented falls on various shifts with various staff. Further review of incident reports revealed client #4 had sustained no injuries after most falls and needed first aid treatment only for abrasions or redness. Review of incident report dated 8/25/19 revealed client #4 was taken to urgent care after a fall due to an elbow laceration. Review of records for client #4 on 1/17/20 revealed a behavior support plan (BSP) dated 8/26/20. Further review of the BSP revealed target behaviors of stomping feet, clenching fists, cursing, screaming, hollering, making threats to staff and peers, telling others what to do, hitting staff/peers, hitting walls with her fist, not caring for her colostomy bag appropriately and throwing feces. Subsequent review of the BSP for client #4 revealed no behavior of falls. Interview with the QIDP on 1/17/20 verified client #4 has had a history of behavioral falls in which the client falls forward after getting upset. The	W 227		

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W 227	Continued From page 7 QIDP further revealed client #4's fall behavior tends to happen after a directive from staff to do something she doesn't want to do. The facility QIDP additionally verified client #4 has had to have medical treatment after a fall two times that she was aware of (8/25/19 and 1/17/20). Subsequent interview with the QIDP revealed client #4's fall behavior should be in the BSP for the client and she thought that it was. The QIDP verified client #4's BSP should be amended to include fall behavior and a discussion had recently occurred with the facility behaviorist regarding client #4's falls.	W 227		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to furnish and provide teaching relative to eyeglasses for 2 of 3 sampled clients (#1 and #4). The finding is: A. The facility failed to provide teaching relative to eyeglasses for client #1. For example: Observation of client #1 throughout the 1/16-17/20 survey revealed the client to not wear glasses or be prompted by staff to put on glasses.	W 436	W436 The facility will furnish and provide teaching relative to eyeglasses for clients (#1 and #4). W436 The individualized habilitation plans (IHP)'s for sampled clients (#1 and #4) will be updated to include teaching/training programs relative to eyeglasses. W436 The QP and Group Home Coordinator will provide an In-Service Training to support staff to ensure training occurs with Client #1 relative to wearing eyeglasses and the need to keep up with them. W436 Client # 4 now has her eyeglasses and is wearing them as prescribed.	3-2-2020 3-2-2020 3-2-2020 1-27-2020

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W 436	Continued From page 8 Review of records for client #1 on 1/17/20 revealed a vision exam dated 8/29/19. Further review of the 8/2019 vision exam revealed a diagnosis of myopia and Presbyopia. Subsequent review of the 8/2019 vision exam revealed prescribed glasses with a recommended follow-up exam in one year. Interview with the qualified intellectual disabilities professional (QIDP) on 1/17/20 revealed client #1 has prescribed glasses that the client should wear at all times. Further interview with the QIDP revealed client #1 often hides her glasses or loses them due to not wanting to wear them. The QIDP further confirmed client #1 did not have a training program to address wearing eyeglasses or the need to keep up with eyeglasses. B. The facility failed to furnish eyeglasses for client #4. For example: Observation of client #4 throughout the 1/16-17/20 survey revealed the client to not wear glasses or be prompted by staff to put on glasses. Review of facility incident reports on 1/17/20 revealed on 9/6/19 client #4 had a fall and sustained an abrasion to the forehead. Further review of the 9/6/19 incident report revealed client #4's glasses broke with the client's fall. Review of records for client #4 revealed a vision exam dated 1/2/20 that indicated a new prescription for glasses was provided with exam. Interview with the QIDP verified client #4 currently did not have glasses. The QIDP further verified client #4 had not had glasses furnished since the last pair broke in 9/2019. Additional interview with the QIDP revealed client #4 currently has	W 436		

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W 436	Continued From page 9 eyeglasses ordered although the glasses had not come in. The QIDP subsequently confirmed client #4 had been without prescribed eyeglasses for 4 months.	W 436		

SUBJECT: **Emergency and Evacuation Policy**

POLICY # 119
Dated: 10/4/04
Revised: 08/19

POLICY

The purpose of this policy is to ensure that all employees fully understand the actions to take if a home/program evacuation is necessary in the event of a natural disaster or if an act of violence (or the threat of violence) against any individual, staff, or home/program occurs. Although the safety of all personnel is paramount, staff must be prepared to prioritize assisting individuals to safety. It should be noted that this policy contains guidelines to work in conjunction with the Arc of Haywood County's Emergency Management and Communication Plan.

PRACTICE

When to call or text ***911***
In every situation in which the safety or welfare of an individual or employee is threatened, either immediately or imminently, a staff member will call or text 911.

The term "emergency" refers to any situation, which is sudden and/or unforeseen, such as a natural disaster, fire or other catastrophe which necessitates the removal of individuals from the home/program to protect their health and safety. The term does not apply to emergency placements of individuals outside of a home/program due to behavior problems. A few examples are listed below that fall within the category of "emergency":

- Adverse weather or other natural occurrence in which allowing individuals and staff to remain in the home/program may jeopardize their health or safety;
- A home/program fire, poor or non-functioning heating or cooling system (in cold and hot weather, respectively), poor or non-functioning septic system, or other situation in which allowing individuals/staff to remain in the home/program may jeopardize their health or safety; and
- Any other unforeseen occurrence not noted above in which allowing individuals/staff to remain in the home/program may jeopardize their health or safety.

Following is a partial list of events or situations that would prompt a call or text to 911, either to report an emergency or to request advice regarding an emergency.

- Any natural or man-made disaster affecting a home/program
- Chemical spills in or near a home/program
- Threats against The Arc of Haywood County, a home/program, staff, or individuals, including a bomb threat or active assailant.
- Serious weather emergencies such as heavy snow, tornado, flood, or ice storm with direct impact to home/program
- Downed trees or power lines on or near a home/program
- Fire in or near a home/program
- Terrorist threats or events affecting the local area
- Intruder(s) in a group home or attempting entry
- Missing or lost person-15-minute waiting period

The staff member making a 911 call shall identify himself/herself and state that an emergency involving a home for IDD adults exists. Relate home address as well as the nature of the 911 call. State the number of people in the home.

SHORT-TERM EVACUATION

In case of short-term evacuation, i.e., power failure, unsafe environment, the individuals may be relocated to another home, main office or community setting, i.e., restaurant, public library, shelter or other designated area. Details can be found in the emergency management and communications plan.

For extended evacuation periods:

- To another Arc home that is not also impacted by the emergency.
- If overnight accommodations are required, plan with other designated area (shelters) which the Director(s) of Service and/or the Executive Director deem appropriate. This decision may be made in conjunction with other HCHHSA and/or emergency management officials of Haywood County.
- In some instances, overnight accommodations could be local hotels/motels should emergency management officials deem necessary.

Since an emergency may necessitate an extended evacuation, it is critical that every staff person is knowledgeable regarding the following individual information: current medications, names of individual physicians, names of pharmacies, and any special individual needs.

Individual Information Sheets *must* be kept current and retained in agency vehicles. When a home is evacuated personal cell phones of staff can be taken with staff. A copy of this policy shall be posted in each home prominently and adjacent to a telephone. Staff shall ensure that evacuated individuals are provided cover, safety, adequate food, and acceptable environmental temperatures.

Emergency Evacuation Procedures

A. Each group home shall post ***Fire Evacuation Procedures*** approved by the Fire Marshal, as well as evacuation procedures for other emergencies.

B. Staff and individuals will be familiar with these procedures.

C. If the emergency affects the home or surrounding area only, the individuals may be relocated to another home, The Arc office or community setting. If the situation deems overnight accommodations, contact the Director(s) of Service and/or Executive Director for assistance and instructions.

D. In the event of a county-wide/ large-scale disaster or emergency, the following:

1. Monitor local news broadcasts and stay in contact with the administrative office/Director(s) of Service/Executive Director.

2. If instructions from Emergency Management/ HCSD & HCHHSA include evacuation to central areas/shelters these steps will be followed:

   A. The Director(s) of Service/Executive Director will contact the Haywood County 911 Communications Center (452-6600) to request a return contact by the Haywood County Health & Human Services Adult Service On-Call Worker. If the Director(s) of Service is unavailable, the Executive Director will make this contact.

B. The need to evacuate will be disclosed by the Director of Services to the Haywood County Health & Human Services On-Call Worker who will then contact the Haywood County Health & Human Services Adult Services Director.

C. The Adult Services Director will communicate to the Director(s) of Service a designated shelter site.

D. The Director(s) of Service/Executive Director will notify the Home Coordinator and/or staff on duty of the designated shelter site.

E. The Home Coordinator and/or the staff on duty will facilitate the evacuation steps of compiling the necessary emergency supplies (food, bedding and clothing). Staff will transport individuals to the designated shelter along with the appropriate charts and medications and will work with emergency personnel for them to safely transport individuals and staff.

F. Staff and individuals will remain at the designated shelter until the appropriate authorities give approval to leave.

A list of emergency food supplies (See Appendix 61-A) and emergency supplies (See Appendix 61-B) will be kept in each home/program.

The following is a list of some emergency telephone numbers and resource information:
For a full list of detailed telephone numbers look to the Emergency Management and Communication Plan.

Telephone Numbers- In the event of an emergency- CALL or TEXT 911 to activate public safety

Emergency Information:	Phone	Email and/or website/address
Emergency	911	cmorgan@haywoodnc.net
Haywood County Sheriff Dept.	452-6666	gchristopher@haywoodnc.net
Fire Station #2- Hazelwood	456-8648	
Waynesville Fire Station	456-6151	
Lake Junaluska Fire Station	452-4404	
Greg Shuping, Emergency Services Director	356-2701	gshuping@haywoodnc.net
Haywood Co. Health & Human Services Agency	452-6620 or 452-6613	tsblevins@haywoodnc.net
North Carolina Poison Control	800-222-1222	http://www.aapcc.org/
Local News WLOS Channel 13	456-6020	http://wlos.com/

Non-emergency Information:	Phone	Email and/or website/address
Non-emergency operations center	452-6600	
Non-emergency police - Interim Captain Brian Beck cell : 828-646-0841)	456-5363	bbeck@waynesvillenc.gov
Non-emergency fire - Joey Webb	456-6151	jwebb@waynesvillenc.gov

Radio Stations

- Channel WOXL 970 AM - 800-815-9650 http://www.965woxl.com/
- Channel WMXF 1400 AM - 456-8661 http://tunein.com/radio/The-Peak-1400-s21313/
- Channel WQNS 105.1 FM - 257-2700 http://1051rocks.iheart.com/features/contact-us-301/
- Channel WPTL 920 AM - 648-3576 http://wptlradio.net/

Local Shelters

- Haywood County Health & Human Services Agency - 157 Paragon Parkway, Clyde, NC 28721, **452-6620 Contact: Emergency & Crisis Response Team/On Call Responder**
- Tuscola High School - **564** Tuscola School Rd, Waynesville, NC 28786-**456-2408 Contact: Todd Trantham**
- Waynesville Middle School - 495 Brown Ave, Waynesville, NC 28786, **456-2403 Contact: Todd Barbee**
- Folkmoot Center, Waynesville (Old Hazelwood School) - 112 Virginia Ave, Waynesville, NC 28786, **452-2997 Contact: Angelina Schwab**

NOTE: PLEASE LISTEN TO EMERGENCY ANNOUNCEMENTS FOR DESIGNATED SHELTERS.

Each year staff will receive training on ***Emergency and Evacuation procedures*** and renew ***annually***. Staff will also receive training upon hire. (See Appendix 61)

Licensed Facility to Licensed Facility

If individuals are moved from one licensed facility to another licensed facility and the capacity for that facility ***will not be exceeded***, it is not necessary to notify DHSR.

Licensed Facility to Unlicensed Facility or to Licensed Facility Exceeding Capacity

When a facility must move individuals from a licensed facility to an unlicensed facility due to an emergency as described on Page 1 of this **Emergency and Evacuation Policy,** it is recommended the facility, its director, owner or designee do the following:

1. First, ensure the safety and health of the individuals by evacuating them to a safe and secure facility where the individual's health needs will be met. There must be enough staff, food, medicine, medical equipment and supplies to ensure the safety and health needs of the individuals.
2. As soon as possible after evacuation, notify DHSR Mental Health Licensure and Certification Section ***(919) 855-3795*** or DHSR Construction Section ***(919) 855-3893*** via phone and explain the situation and the reason for relocating the individuals. https://www2.ncdhhs.gov/dhsr/requests.htm
3. Submit in writing by facsimile (919) 715-8077 or mail the following information to the DHSR MH Licensure and Certification Section:

- Explanation and rationale for evacuating the facility and moving the individuals to a new location.
- The name and address of the site where the individuals were relocated.
- How the facility can be contacted.
- How the facility implemented their emergency plan in accordance with 10 NCAC 27G.0207 – Emergency Plans and Supplies.
- A copy of the facility's emergency management and communications plan. This plan should include the identification of potential evacuation sites to which individuals might be moved in the event of an emergency with assurance that the evacuation site will be able to accommodate the health and safety needs of the individuals.
- When the provider anticipates moving the individuals back to the facility/home/program or, in the case where the facility cannot be used (i.e., destroyed or otherwise unavailable for use), what provisions the provider is making to place the individuals in a suitable setting.
- Names and phone numbers of all client case managers including the date the case managers were notified of the evacuation and relocation.

4. If the facility cannot be used in the immediate future, the provider must have a plan for relocating the individuals to a permanent licensed setting. DHSR will work with the provider to license a new facility/home/program as soon as possible. Again, these decisions may be made in coordination with county and emergency officials.

Tornado Procedure

The following procedure will be utilized for tornado drills and in the event of the actual occurrence of a tornado. All facilities/homes/programs are equipped with a weather radio with battery back-up for weather alerts.

1. If the tornado siren has been sounded or the home has been alerted in some other way that a tornado has been spotted in the area, all individuals and staff will proceed to the most inside protected area of the house.

2. Remain calm, follow directions and do not leave the area or the home until you have been told it is safe to do so.

3. All individuals will sit or lay on the floor with their heads covered, and backs against a wall until danger has passed. Use arms and hands to protect head and neck.

4. When the all clear siren has sounded, or the home has been alerted in some other way that the tornado has passed, all individuals and staff will be able to return to other areas of the house.

5. When all danger has passed staff should contact the Director(s) of Services. If they are unavailable or unreachable call the Executive Director immediately. If there are injuries, these should be attended to immediately and additional care provided if needed. Staff should follow treatment of injuries as outlined in Major/Minor Medical Emergencies section of the Emergency Management and Communication Plan. If there is damage to the home, evacuation procedures should be followed. All reporting should be completed as soon as possible, to include but not limited to incident reporting for individuals and employee injury and illness reporting. Blood borne pathogen reporting may be utilized as well.

Drills will be performed quarterly, and in accordance with state and federal regulation. Drills will be completed at least one per shift per quarter and will be documented on the ***Fire/ Disaster/ Power Failure Drill Summary*** (Appendix #67) and ***Fire / Disaster / Power Failure Drill Report*** (Appendix #68).

For complete listing of all organizational procedures on emergency and evacuation procedures please see the Emergency Management and Communication Plan booklet.

PLAN REVIEWED BY: _____ **DATE:** _____
Zach Koonce, Operations Officer, Haywood County Emergency Services

THE ARC OF HAYWOOD COUNTY
EMERGENCY FOOD SUPPLY INVENTORY

(Group Homes must maintain a 3-day emergency food supply. The following items and quantities must be checked every 2 months. The items must be rotated out every 6 months.)

ITEM DESCRIPTION	QUANTITY	DATE/INITIALS	DATE/INITIALS	DATE/INITIALS	ALL STOCK ROTATED DATE/INITIALS
Apple Juice	(1) Lg. Bottle				
Grape Juice	(1) Lg. Bottle				
V-8 Juice	(1) Lg. Bottle				
Bottled Water	(3) 24-packs				
Water	(8) Gallon jugs				
Crystal Light Singles	(3) Boxes				
Cereal-Cheerios	(1) Lg. Box				
Cereal-Shredded Wheat Minis	(1) Lg. Box				
Granola Bars (Variety)	(1) 24-pack				
Cereal Bars	(1) 24-pack				
Snack Crackers (individual Packs)	(1) 8-packs				
Saltine Crackers	(1) Box				
Ritz Crackers	(1) Box				
Pringles	(3) Cans				
Pudding Cups (sugar-free)	(1) Lg. Box				
Peanut Butter	(1) 16 oz. jar				
Vienna Sausage	(8) Sm. Cans				
Beanee Weenees	(8) Sm. Cans				
Deviled Ham	(8) Sm. Cans				
Tuna	(8) Sm. Cans				
Chunk Chicken Breast	(8) Sm. Cans				
Applesauce Cups	(3) 6-packs				
Fruit Cups	(2) 12-packs				
Raisins	(1) Lg. Canister				
Instant Dry Milk	(1) Lg. Box				

The Arc of Haywood County

Emergency/Disaster Supply Inventory

ITEM/DESCRIPTION	*QUANTITY*	***Check q 3 mos.*** *Date/Initials*	***Check q 3 mos.*** *Date/Initials*	***Check q 3 mos.*** *Date/Initials*	***Check q 3 mos.*** *Date/Initials*
Tarp 8'x10'	2				
Clothesline rope	1 pk				
Toboggans	8				
Sleeping bags	8				
Flashlights w/ batteries	3				
Batteries—AA, C, D	8 each				
Emergency weather radio	1				
Toilet paper	4 pk				
Paper towels	3 rolls				
Foam plates, bowls, cups	1 pk each				
Plastic spoons and forks	1 pk each				
Baby wipes	1 tub				
Soap, shampoo, toothpaste, deodorant (trial size)	8 each				
Mr. Heater Buddy (heat source)	1				
Small propane canisters (for heater)	8				
Hand towels	8				
Sanitary pads	1 lg bag				
Toothbrushes & Hair brushes	8 each				
Hand sanitizer	1 lg bottle				
Kitchen matches in Ziploc bag	1 lg box				
Emergency candles	12				
Light sticks	8				
First aid kit w/ CPR mouthpiece	1				
Portable Oxygen Tank as needed by clients.					

*** Check stock every 3 months to ensure availability***

most supplies can be purchased at Dollar Tree, buy multi packs when possible

Attachment 28

The Arc of Haywood County

IN-SERVICE TRAINING FORM

TRAINER: Tammy Inman DATE 2-5-2020

1. **Purpose of training:**
   a. This training addresses the Emergency Management Plan.
   b. This training addresses the Emergency Supplies/Subsistence needs of the group home. (Also review Appendix #61-A Emergency Food Supply and Appendix #61-B Emergency/Disaster Supply Inventory)
   c. This training addresses specifics related to where the Emergency Supplies are located and information specific to details of the delegated emergency supplies. (Also review Appendix #61-A Emergency Food Supply and Appendix #61-B Emergency/Disaster Supply Inventory)
   d. This training will be an in-service training of Emergency and Evacuation Policy #119.
   e. This training will review where client-specific information can be found in the event of an emergency or evacuation occurs.
      i. Client specific information that can and will be utilized during an emergency can be found in the company vehicle per Policy #119.
      ii. In the event of an evacuation, Staff will take the laptop which will also provide access to needed client specific information that may be needed.
      iii. Per emergency evacuation procedures, Policy #119, page 3 of 6, step E :".....staff will transport individuals to the designated shelter along with the appropriate charts (Medical Records) and medications…

Debbie Warren

Signature & Dates:

Debbie Warren aHC — 2-5-2020

Employee — Date

Emily Mercer

DSPS — 2-5-2020

Employee — Date

Tonya Grooms

Tonya Grooms DSPS — 2-5-2020

Employee — Date

Helen Espinoza

Helen Espinoza, QP — 2-5-2020

Employee — Date

Ginger Parker

Ginger Parker QP — 2-5-2020

Employee — Date

_____ — _____

Employee — Date

_____ — _____

Employee — Date

_____ — _____

Employee — Date

Please document here if employee refuses to sign: _____