STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G273	A. BUILDING _____ B. WING _____	02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHSIDE GROUP HOME	3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301

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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 every 2 years. 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.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC 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, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID 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: (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):] Emergency	E 006		

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 006	Continued From page 1 Plan. The Hospice 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: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (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: Based on record review and interview, the facility failed to develop an Emergency Preparedness (EP) plan including and based upon a community and facility-based risk assessment, utilizing an all-hazards approach. The finding is: The facility's emergency plan did not include a risk assessment. Review on 2/8/21 of the facility's current EP plan dated 2018 revealed the plan did not provide specific information in regards to a facility-based and/or community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types. Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no risk assessment had been completed during the development of the emergency plan utilizing an all-hazards approach.	E 006		
W 224	INDIVIDUAL PROGRAM PLAN	W 224		

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W 224	Continued From page 2 CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the comprehensive functional assessment included meal preparation skills for 3 of 4 audit clients (#2, #3 and #4). The finding is: During morning observations in the home on 2/9/21 from 6:32am - 7:07am, Staff F cooked the breakfast meal without any assistance from clients. Although several clients were sitting nearby in the living room, no clients were prompted or encouraged to participate with any cooking tasks. During an interview on 2/9/21, when asked if the clients assist with cooking in the morning, Staff F indicated she does not usually work in the morning but she thought the clients did participate with cooking. The staff stated, "That's on me." Review on 2/8/21 of client #2's, client #3's and client #4's record did not reveal an assessment of their meal preparation skills. Interview on 2/9/21 revealed the clients should participate with cooking tasks; however, an assessment of their meal preparation skills had not been completed.	W 224		
W 227	INDIVIDUAL PROGRAM PLAN	W 227		

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W 227	Continued From page 3 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 record review and interview, the facility failed to ensure client #4's Individual Program Plan (IPP) included objectives to address his needs. This affected 1 of 4 audit clients. The finding is: Review on 2/8/21 of client #4's IPP dated 11/6/20 revealed priority needs and formal objectives for Personal Hygiene (shaving), Pre-vocational (packaging) and Behavior management (behavior plan). The plan noted, "All needs deemed as priorities by the team are addressed by formal goals." Additional review of the plan also identified needs for "formal programs" in the areas of communication, self-help and structured activities; however, no other formal objectives were available for review. Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 continues to have needs in the identified areas; however, no formal objectives have been implemented to address those needs.	W 227		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual	W 240		

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W 240	Continued From page 4 toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included specific interventions to support his independence towards using his communication device. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 2/8 - 2/9/21, client #4 was non-verbal and communicated his wants and needs through vocalizations and physical movements. The client was no prompted or assisted to utilize any assistive communication devices during interactions with staff. During an interview on 2/9/21 with Staff E, when asked how client #4 communicates with them, the staff stated, "He don't...We have to figure it out." Review on 2/9/21 of client #4's IPP dated 11/6/20 revealed, "[Client #4] in non-verbal. He does use a Spelling Ace for basic wants such as eat and drink." Additional review of the plan did not include any specific information regarding the use of client #4's communication device. Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 uses a Spelling Ace communication device. The QIDP acknowledged the client's IPP does not include information regarding the use of his device.	W 240		
W 312	DRUG USAGE CFR(s): 483.450(e)(2)	W 312		

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W 312	Continued From page 5 Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a drug used to manage client #4's inappropriate behaviors was used only as an integral part of his Individual Program Plan. This affected 1 of 4 audit clients. The finding is: Review on 2/8/21 of client #4's behavior plan revealed an objective to demonstrate no more than 1 episode of his target behaviors per month for 6 consecutive months. The plan identified target behaviors of tantrums and property destruction. Additional review of the plan noted the use of Risperdal and Gabitril to address his target behaviors. Further review of client #4's physician's orders dated 2/1 - 2/28/21 also revealed an order for Atarax, take 1 tablet by mouth at bedtime for sleep and anxiety at 8pm. The use of Atarax was not included in client #4's behavior plan. Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 ingests Atarax for behavior control; however, the medication was not included in his behavior plan.	W 312		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i)	W 340		

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W 340	Continued From page 6 Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, staff interviews, records and policies review, the facility failed to adequately train staff on proper glove use, disinfecting shared equipment, not utilizing full COVID-19 screening measures with visitors which had the potential to affect all clients; as well as not following recommendations for clients #3 and #6 for self-medication administration. The findings are: A. During observations in the home on 2/8/2021 at 9:45 am, staff B and staff F were present and allowed the surveyors to enter without asking any COVID-19 screening questions about symptoms or potential exposure and did not attempt to record our body temperatures. Surveyors worked in the home, amongst staff and clients until the qualified intellectual developmental professional (QIDP) arrived at 10:00 am and asked to take our body temperatures. The QIDP did not take further actions to ascertain if the surveyors had been exposed to COVID-19 or had any COVID-19 symptoms. During observations in the home on 2/9/21 at 6:45 am, staff F allowed the surveyor to enter the home and did not ask to take body temperature or ask any screening questions. At 6:50 am, the QIDP approached the surveyor and recorded body temperature but did not ask screening	W 340		

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W 340	Continued From page 7 questions. On 2/8/21, a review of the facility's screening log revealed that 3 staff working first shift and the 2 surveyors had their body temperatures recorded. There were no information on the log, that asked questions about current symptoms or exposure to anyone with COVID-19. An interview with the QIDP on 2/9/21 revealed that she did not know they had an option to ask COVID-19 screening questions; their practice was to only record body temperatures. The QIDP further stated that she "had to get on staff for not screening a repairmen" who did work in the home. An interview with the registered nurse (RN) on 2/9/21 revealed that last year, "midway through the pandemic" she faxed over a form to the facility, at their request, that she took off the center for disease control (CDC) website, that asked COVID-19 screening questions about symptoms like coughing and potential exposure to COVID-19. The RN also stated that she had COVID-19 training at the home as well as the QIDP performs training too. B. During observations in the home on 2/8/21, a blue cloth tablecloth and 6 striped placemats adorned the dining room table. The clients were engaged in leisure activities during the morning, using puzzle pieces, container full of crayons and coloring book. After the activities ended, none of the equipment was wiped down before the clients returned to the table to get ready for lunch at noon. The table setting was not disinfected after lunch and the clients #1, #2, #3, #4 and #6 sat at the clothed dining room table, using electronic	W 340		

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devices, playing cards, building pieces, coloring books and crayons. The game pieces were cleared from the table before dinner began at 5:30 pm, and there was no observation of the table setting being disinfected before the food was brought to the table in bowls.

Interview with the QIDP on 2/9/21 revealed that the facility washed the cloth tablecloth at night but she acknowledged that they were not disinfecting contents on the dining room table between activities.

Interview with the RN on 2/9/21 revealed that she mainly concentrated on medications and occupational safety and health act (OSHA) and thought it was the responsibility of the home manager to train staff on infection control measures. The RN acknowledged that she was over infection control and commented that it "slipped through the cracks." The RN stated that staff should have developed a cleaning schedule to wash and clean items, after use.

C. During observations in the home on 2/8/21 between 12:41-12:47 pm at medication administration, staff F pre-prepared pills in a cup for clients #3 and #6 before they entered the room. Staff F did not involve them in any of the medication administration tasks which included removing pills from blister packs, pouring water into cups, discussing the names and reasons for taking their medications and discarded their trash afterwards.

Review on 2/9/21 of the facility's Medication Administration policy, dated 3/1/13 revealed direct care staff and supervisors will be trained annually by a licensed nurse on education/training process

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W 340	Continued From page 9	W 340		

and risk prevention activities. A systematic monitoring and evaluation system was in place to ensure that standards of quality of care were met.

Interview with staff F on 2/8/21 revealed that she did not follow policy because she was nervous being observed. Staff F also commented that she did not go over the purpose of the medication, but it was already discussed with the clients during morning medication administration.

Interview with the QIDP on 2/9/21 revealed that the nurse has provided ongoing training with the staff on medication administration. She further stated that it was important for the clients to participate in medication administration because it taught independent living skills.

Interview with the RN on 2/9/21 revealed that when she has provided training to staff, they were encouraged to allow clients to participate in pouring their liquids and taking their cups to the sink. The RN stated that all hired staff have been trained at hire to administer medications.

D. During observations in the home on 2/8/21 from 4:16pm - 5:55pm, Staff C periodically wore latex gloves while interacting with clients during leisure activities, manipulating items in the kitchen and assisting clients during the dinner meal. The staff did not consistently change the gloves between interactions throughout the observations.

During observations in the home on 2/9/21 from 6:35am - 8:00am, Staff E periodically wore latex gloves while performing cleaning tasks and assisting clients at the breakfast meal. At 7:25am and 7:35am, Staff E prompted two clients to

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W 340	Continued From page 10 brush their teeth independently and then brushed their teeth for them. The staff did not wear gloves during this task. Interview on 2/8/21 with Staff C revealed gloves should be worn "at all times" when interacting with the clients. Interview on 2/9/21 with Staff E revealed they wear gloves when assisting clients with "really very, very hands-on" activities. The staff identified activities such as bath time, medication administration, meals and cleaning tasks. Review on 2/9/21 of the facility's policy for latex glove use (revised 7/20/17) revealed, "Wear gloves when touching blood, body fluids, secretions, excretions or mucus membranes...Change gloves between tasks/procedures on the same consumer to prevent cross contamination..." Interview on 2/9/21 with the QIDP confirmed staff have been trained to wear gloves as noted in the policy.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, staff failed to administer 1 of 4 audit client's (#3) medications without error. The findings is:	W 369		

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W 369	Continued From page 11 During medication administration observations on 2/8/21 at 12:46 pm, staff F took a bottle of eye drops and squeezed the bottle, instilling 2 drops into client #3's right and left eyes. Review on 2/8/21 of client #3's physician orders dated 1/31/21, revealed to instill 1 drop of Refresh Optive Advance into each eye. An interview with staff F on 2/8/21 revealed that she thought she gave him one drop in each eye.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure all medications remained locked. This had the potential to affect all clients in the home. The findings is: During medication administration on 2/8/21 at 12:43 pm, staff F had prepared in advance, a cup containing 4 pills of Gabapentin 100 mg, a controlled substance and left it on the table. Staff F then walked out of the office and went to the den, to tell client #4 it was time to take his medications, leaving the surveyor in the room alone. At 12:45 pm, staff F gave client #4 the pills to swallow. At 12:47 pm, after client #3 finished taking his medications, staff F left the bottle of eye drops on the table as she walked toward the doorway to call for the next client, while the	W 382		

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W 382	Continued From page 12 surveyor remained near the med cart. Interview with staff F on 2/8/21 revealed that she was nervous and normally does not walk away from the medications. Interview with the registered nurse (RN) on 2/9/21 revealed that staff have been trained to stay with medications at all times and to never leave medications unattended.	W 382		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure only authorized persons had access to the drug storage area. The finding is: During observations in the home throughout the survey on 2/8 - 2/9/21, the keys to the medication cart was periodically noted attached to a lanyard and hanging from a table lamp in the dining/living area of the home. Various staff consistently retrieved the set of keys, used them and returned the keys to the same location. The keys to the medication cart were accessible to anyone in the home. Review of the facility's Medication and Medical Policies (last updated 12/17/12) revealed, "...only those persons authorized to prescribe or administer medication shall have access to stored medications. The key will be in the	W 383		

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W 383	Continued From page 13 personal possession of identified staff." Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the keys to the drug storage area should kept on the person administering medications and not accessible to others.	W 383		