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 _____	R 06/28/2021

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) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(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 Hospices at §418.113(a):] Emergency 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. *[For LTC facilities at §483.73(a):] 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 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):] 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. 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: Review on 6/28/21 of the facility's current EP risk assessment revealed the plan only addressed floods and did not provide specific information in regards to a facility-based and/or community-based assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types.	{E 006}		

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{E 006}	Continued From page 2 Interview on 6/28/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the risk assessment only identified floods and did not include an all-hazards approach.	{E 006}		
W 000	INITIAL COMMENTS A revisit was conducted on 6/28/21 for deficiencies previously cited on 2/8 -2/9/21. Five deficiencies were recited and two new areas of non-compliance were identified. The facility remains out of compliance.	W 000		
{W 224}	INDIVIDUAL PROGRAM PLAN 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 (CFA) included meal preparation skills for 1 of 4 audit clients (#5). The finding is: During morning observations in the home on 6/28/21 from 6:30am - 6:52am, Staff A prepared the individual bowls of oatmeal using the microwave without any assistance from clients. With the exception of one client placing fruit cups on the table, no clients were prompted or encouraged to participate with any cooking tasks. During an interview on 6/28/21, when asked if the clients assist with cooking in the morning, Staff A	{W 224}		

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{W 224}	Continued From page 3 indicated he was not sure and does not usually work in the kitchen in the morning. The staff stated, he "really never had to play this role." Review on 6/28/21 of client #5's CFA (last updated 3/27/21) did not reveal an assessment of his meal preparation skills. Interview on 6/28/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the clients, including client #5, should participate with cooking tasks; however, an assessment of client #5's meal preparation skills had not been completed.	{W 224}		
W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure objectives for 1 of 4 audit clients (#4) were stated in a manner which permits them to be measured with quantifiable data. The finding is: Review on 6/28/21 of two objectives statements for client #4 revealed the following: A. "[Client #4] will be given opportunities throughout the day by staff to make choices of things or items he may want." B. "Each day staff will arrange for the client to engage in structured leisure activities...for 30	W 231		

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W 231	Continued From page 4 minutes to an hour daily." Additional review indicated the objective statements were not written in behavioral and measurable terms. Interview on 6/28/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's objectives statements were not written with measurable criteria.	W 231		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of meal preparation. This affected 2 of 4 audit clients (#3 and #6). The finding is: During morning observations in the home on 6/28/21 from 6:30am - 6:52am, Staff A prepared individual bowls of oatmeal using the microwave without any assistance from clients. During the observation, client #6 sat nearby watching and	W 249		

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W 249	Continued From page 5 client #3 entered the area and asked the staff if they needed any help with cooking and was told "No". With the exception of client #6 placing fruit cups on the table, no clients were prompted or encouraged to participate with any cooking tasks. During an interview on 6/28/21, when asked if the clients assist with cooking in the morning, Staff A indicated he was not sure and does not usually work in the kitchen in the morning. The staff stated, he "really never had to play this role." Review on 6/28/21 of client #3's Comprehensive Functional Assessment (CFA) dated 3/13/21 revealed he requires assistance to use the stove/microwave oven for cooking, prepare items that require mixing and cooking, measure items for cooking and prepare an adequate cold breakfast. Review on 6/28/21 of client #6's IPP dated 12/18/20 revealed, "[Client #6] will be provided with assistance as needed for her to complete the task she is working on as independently as possible." The plan noted, "She requires verbal prompts to complete other basic living skills..." Further review of the client's CFA dated 3/27/21 indicated she can prepare a sandwich for lunch. Interview on 6/28/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should be involved with all meal preparation tasks.	W 249		
{W 312}	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the	{W 312}		

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{W 312}	Continued From page 6 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 6/28/21 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 5/1 - 5/30/21 also revealed an order for Vistaril 50mg, take 1 capsule by mouth at bedtime at 8pm. The use of Vistaril was not included in client #4's behavior plan. Interview on 6/28/21 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager (HM) confirmed client #4 ingests Vistaril 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) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health	{W 340}		

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{W 340}	Continued From page 7 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 interview, and record review, the facility failed to adequately train staff on proper latex glove use and utilizing full COVID-19 screening measures with visitors which had the potential to affect all clients. The findings are: A. Upon arrival to the home on 6/28/21 at 6:30am, Staff A did not provide any COVID-19 screening for the surveyor prior to entering the home. At 6:55am (25 minutes later), after being questioned by the surveyor regarding the facility's COVID-19 screening protocol, the staff took the surveyor's temperature, asked if any symptoms were present and recorded the information on a log sheet. Interview on 6/28/21 with Staff A revealed staff screen themselves upon arrival to work and each client's temperature is also taken daily. The staff indicated he was not aware of any screening required for visitors to the home. Interview on 6/28/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the staff should be screening all visitors according to the facility's screening procedures prior to entering the home and documenting this information. B. During morning observations in the home on 6/28/21 from 6:35am - 7:22am, Staff A continuously wore a single pair of latex gloves	{W 340}		

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{W 340}	Continued From page 8 while performing cleaning tasks, cooking the breakfast meal, manipulating cabinet knobs, door handles and light switches, and handling a cell phone, telephone and a book. The staff did not perform any client care tasks while wearing the gloves. Interview on 6/28/21 with Staff A revealed they had been trained to wear latex gloves when dispensing medications and cooking. Review on 6/28/21 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..." Interview on 2/9/21 with the QIDP confirmed staff have been trained to wear gloves as noted in the policy and she was not sure why the staff was wearing the gloves.	{W 340}		
{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 morning observations in the home on 6/28/21 from 6:30am - 7:22am, the key to the medication cart was noted attached to a lanyard and hanging from a door knob in a back hallway of the home or hanging from a table lamp in the	{W 383}		

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{W 383}	Continued From page 9 dining/living area of the home. 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 personal possession of identified staff." Interview on 6/28/21 with Staff A revealed he normally hangs the keys from the lamp in the dining/living area for easy access to the medication cart or he places them in a file cabinet drawer in the office area. Interview on 6/28/21 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}		