STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G353	A. BUILDING _____ B. WING _____	11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRY HOUSE	1793 BRILEY ROAD GREENVILLE, NC 27834

(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 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and	E 025	Preparation and execution of this Plan of Correction does not constitute admission of agreement by the provider or the truth of facts alleged or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X3) DATE
Cynthia B. Stevens	Program Director	12/6/2021

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 025	Continued From page 1 procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Manual (EP), the facility failed to document pre-arranged accommodations for clients in the event services could not be delivered in the home. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) in the home. The findings is: Review on 11/15/21 of the facility's 2021 EP revealed there was no listing of accommodations or agreements for housing for emergency purposes. During an interview on 11/15/21 with the Qualified Intellectual Disabilities Professional (QIDP), she acknowledged that the EP did not list any specific location as an option to relocate clients.	E 025	E025 DP will update the Emergency Preparedness Manual to include agreement(s) for housing for long-term emergency purposes. Plan to prevent re-occurance: Emergency Preparedness Plan and agreement(s) will be reviewed and updated annually by the PD.	1/16/2022
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(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	E 036		

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E 036	Continued From page 2 §485.920, OPOs at §486.360, and 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 facilities 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, 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).	E 036		

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E 036	Continued From page 3 *[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 review and interviews, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Review on 11/15/21 of the facility's EP plan (last updated 4/2020) did not reveal direct care staff had received recent training on the plan. Additional review of the EP plan manual did not include training for all staff working at the home. During an interview on 11/15/21, the Qualified Intellectual Disabilities Professional (QIDP) indicated no current training on the facility's EP plan had been completed. Additional interview revealed she could not be sure of the last time staff working in the home had been trained on the plan.	E 036	E036 PD will in-service staff on the Emergency Preparedness Plan. Staff will monthly training to include table top exercises. Plan to prevent re-occurrance: Monitoring will take place monthly during QI meetings with QA Specialist.	1/16/2022
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restrictive Behavior Support Plan (BSP) was conducted with the written consent of the guardian. This affected 1 of 4 audit clients (#4). The finding is: Review on 11/16/21 of Client #4's BSP dated 10/11/21 revealed objectives that across all settings, Client #4 will participate actively in community life as evidenced by zero reports of injury related to aggressive behaviors for 18 of 18 months by 5/31/23. Additional review of the plan also included the use of Risperidone, Depakote, Desyrel and Benadryl. The BSP failed to mention that Client #4 was still receiving Trazodone at night as a antidepressant. Further review of the record did not include a written informed consent for the BSP from the guardian since 2/6/20. Interview on 11/16/21 with the Program Director indicated the BSP was implemented in April 2020; however no written informed consent was available as of the date of the survey.	W 263	W263 QP will work with Psychologist to update client #4's BSP to include the use of trazodone at night as a antidepressant. QP will obtain guardian's informed consent. Plan to prevent re-occurance: Monitoring will be conducted by QP, QA and PD during quarterly chart reviews, QP reviews and QA reviews.	1/16/2022
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 11/15/2021 of facility fire drill reports for November 2020- October 2021 revealed fire drills were conducted on first shift at 9:17am,	W 441	W441 GHM will inservice staff on the importance of conducting fire drills at varying times and conditions on all shifts. PD will update fire drill schedule to include the time each drill should be conducted monthly. Plan to prevent re-occurrance: Monitoring will be conducted by GHM, QI, PD monthly during CQI meetings.	1/16/2022

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W 441	Continued From page 5 9:17am, 9:00am and 8:50am. Fire drills on second shift were conducted at 5:04pm, 5:08pm, 5:00pm and 5:15pm. Fire drills on third shift were conducetd at 3:24am, 4:31am, 4:00am and 3:31am. The fire drills were not conducted during varied times for all three shifts. During an interview on 11/16/21 with the Program Director revealed the fire drill dates are scheduled by the home manager and the staff working that day determines the specific time to conduct the drill. The program director acknowledged that the drills were not conducted at varying times for either shift.	W 441		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 4 audit clients (#2) received the modified diet as ordered. The finding is: During lunch observations in the home on 11/15/21 at 12:20pm, Client #2 was edentulous and served grilled ham and cheese sandwich cut into 10-12 pieces the size of quarters by Staff D. Client #2 had also chosen a fresh banana and cereal breakfast bar. Client #2 unwrapped the breakfast bar independently, then placed the whole bar in his mouth, without breaking into small pieces first. Client #2 took bites from the banana and ate all of the sandwich pieces without	W 460	W460 LPN will work with dietician to review client #2's current diet. LPN will inservice staff on any dietary recommendations made by the dietician. LPN will inservice staff on Client #2's diet consistency. Plan to prevent re-occurrance: monitoring will be conducted by the GHM, QP, LPN, and PD through mealtime assessments across all meals. At least three mealtime assessments will be conducted each month.	1/6/2022

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W 460	Continued From page 6 incident. An additional observation at 5:10pm, Staff A placed cut strips of boneless pork loin in a small bowl for Client #2 to eat. The meat was covered with gravy. He also consumed chopped garden salad that contained ham, cheese, diced tomatoes with pieces larger than 1/4" and salad dressing without incident. On 11/16/21 at 7:30am, Staff F thinly sliced a whole banana into medallion pieces. Client #2 consumed the bananas without incident. Review on 11/16/21 of Client #2's diet regime dated 1/5/21 revealed a 1/4" inch regular diet with moistened soft meats at each meal. Another observation on 11/16/21 of a Prevent Choking Hazards diagram belonging to the facility illustrated the size 1/4" the size of a pea. Interview on 11/15/21 with Staff A revealed that she did not cut the pork loin into 1/4" pieces because the meat fell apart when removing from the baking dish due to tenderness. Interview on 11/16/21 with the Nurse revealed that the dietician is contracted with the facility and writes up a training program that is shared with the Nurse. The Nurse in turn presents the training to the staff on how to prepare all meals in the home.	W 460		