STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G342	A. BUILDING _____ B. WING _____	C 12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENCE PLACE	**295 AIRPORT ROAD ROCKINGHAM, NC 28379**

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E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] 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) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and 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.	E 037		

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 037	Continued From page 1 (iii) Provide emergency preparedness training at least every 2 years. (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. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[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 every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[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	E 037		

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E 037	Continued From page 2	E 037		

arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(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.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility 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 all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The 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 every 2 years.

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E 037	Continued From page 3 (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. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[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 every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and 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 4 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 every 2 years. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency preparedness (EP) pan. The finding is: Review on 12/5/22 of the facility's EP manual dated 11/30/22 did not include any information regarding training of staff. During an interview on 11/5/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed there was no information included in the EP concerning training of the staff.	E 037		
W 000	INITIAL COMMENTS A recertification and complaint survey was completed on 12/6/22 for intake NC00194401. No deficiencies were cited in relation to the complaint survey however deficiecies were cited in relation the the recertification.	W 000		
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. This STANDARD is not met as evidenced by:	W 189		

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W 189	Continued From page 5 Based on observations, document review and interviews, the facility failed to ensure staff were sufficiently trained in the usage of their personal cell phone while on duty. The finding is: During evening observations in the home on 12/5/22, Staff A was observed sitting in the bedroom of client #4. Further observations revealed Staff A was using his personal cell phone from 6:56pm - 6:58pm and again at 7:08pm. Review on 12/5/22 of their employee handbook revised on 8/15/22 stated, "...employees should not be using cell phones for personal business while working". During an interview on 12/5/22, the Qualified Intellectual Disabilities Professional (QIDP) stated no staff should be using their personal cell phones while on the floor. Further interview revealed all staff are aware of this policy.	W 189		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure training in the area of medication administration for 2 of 5 audit clients (#3 and #9). The findings are: A. During morning medication administration in	W 371		

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W 371	Continued From page 6	W 371		

the home on 12/6/22 at 5:11am, the Licensed Practical Nurse (LPN) punched out the pills for client #3. Further observations revealed the LPN also poured the water for client #3. At no time was client #3 given the opportunity to participate in her own medication administration.

During an interview on 12/6/22, the LPN stated client #3 should have been given the opportunity to participate during medication administration. The LPN revealed client #3 could punch out her pills and pour her water with hand over hand assistance.

During an interview on 12/6/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #3 should have been given the opportunity to participate in the medication administration of her medication.

During an interview on 12/6/22, the Registered Nurse (RN) reported client #3 has never had any goals in the area of medication administration. The RN stated client #3 needs to have a goal in medication administration.

B. During morning medication administration in the home on 12/6/22 at 5:19am, the LPN punched out the pills for client #9. Further observations revealed the LPN also poured the water for client #9. At no time was client #9 given the opportunity to participate in her own medication administration.

During an interview on 12/6/22, the LPN stated client #9 should have been given the opportunity to participate during medication administration.

During an interview on 12/6/22, the QIDP

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W 371	Continued From page 7 revealed client #9 should have been given the opportunity to participate in the medication administration of her medication. During an interview on 12/6/22, the RN reported client #9 has never had any goals in the area of medication administration. The RN stated client #9 needs to have a goal in medication administration. Further interview revealed client #9 can punch out her own pills and pour her water independently.	W 371		