STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G245	A. BUILDING _____ B. WING _____	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINHOOD GROUP HOME	1507 ROBINHOOD RD WILMINGTON, NC 28401

(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 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), §485.542(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

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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 6/19/23 of the facility's EP did not include a risk assessment that identified hazards for their location. Interview on 6/20/23 with the Administrator revealed when the facility identified types of emergencies, they failed to rank the impact on the facility.	E 006		

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E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (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:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and interview, the facility's Emergency Preparedness (EP) Plan failed to include a policy on sheltering in place. The finding is: Record review on 6/19/23 of the EP revealed	E 022		

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E 022	Continued From page 3 there was no policy on how staff and clients should respond to an emergency that required they shelter in place. Interview on 6/20/23 with the Administrator revealed they did not draft a shelter in place policy for their EP.	E 022		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills, per shift, at least quarterly. The finding is: Review on 6/19/23 of the fire drills completed since June, 2022 revealed the facility missed fire drills on third shift in December, 2022 and February, 2023. Interview on 6/20/23 with the Qualified Intellectual Disability Professional (QIDP) and the Administrator revealed they lost several staff on third shift who would have normally conducted the fire drills.	W 440		
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 record review and interviews, the facility failed to conduct fire drills under varying times and conditions. The finding is: Review on 6/19/23 of fire drills conducted since June, 2022 revealed the following:	W 441		

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W 441	Continued From page 4 First Shift: 9/22/22 at 8:08AM 6/6/23 at 8:37AM Second Shift: 10/25/22 at 4:25PM 1/9/23 at 4:30PM Third Shift: 8/30/22 at 11:40PM 11/10/22 at 11:40PM Interview on 6/20/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff have been trained to conduct fire drills at varying times. The QIDP revealed there has been new staff who will need to be retrained.	W 441		