STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency. Review on 4/9/18 of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication. During an interview on 4/9/18, the qualified intellectual disabilities professional (2) (QIDP) revealed if the land line and cell service were all down there was not another way to	E 032		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 032	Continued From page 1 communicated during an emergency.	E 032		
E 036	EP Training and Testing CFR(s): 483.475(d) (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 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 annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[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	E 036		

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E 036	Continued From page 2 paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to develop a emergency preparedness (EP) training and testing program for House #2. The finding is: The facility failed to develop an EP training and testing program. Review on 4/9/18 of House #2's EP manual did not include any information on training or testing of the staff. During an interview on 4/9/18, staff revealed they had not been tested on the EP. When asked, the staff did not know of an alternate site to evacuate, if the house became uninhabitable for the clients and staff. During an interview on 4/9/18, the qualified intellectual disabilities professional (QIDP) confirmed there was no documentation for staff training or tesing regarding the EP for House #2.	E 036		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 5 audit	W 125		

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W 125	Continued From page 3 clients (#8) had the right to be treated with digmity regarding the use of incontinence pads. The finding is: Client #8's dignity was not considered regarding the use of incontinence pads. During morning observations in the home of 4/10/18, client #8 was seated in a recliner in his bedroom with a large incontinence pad positioned underneath him. The pad was visable to anyone in the home. During an interview on 4/10/18, staff revealed the incontinence pad is positioned underneath client #8 due to the fact he will urinate on himself and in the process get the recliner wet. Further interview revealed client #8 wears disposable adult briefs. The staff also stated client #8 is on a "toileting schedule" every two hours. Review on 4/10/18 of client #8's individual program plan (IPP) dated 2/13/18 stated, "[Client #8] does not indicate when he has to urinate. He wears adult disapers and will urinate in the diaper but not the toilet". During an interview on 4/10/18, the qualified intellectual disabilities professional (QIDP) revealed she was unaware of client #8 having a incontinence pad underneath him while he sat in the recliner in his bedroom.	W 125		
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	W 249		

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W 249	Continued From page 4	W 249		

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 reviews and interviews, the facility failed to ensure 3 of 5 audit clients (#1, #7, #8) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of free movement and diet consistency. The findings are:

1. Clients #8 and #1 were not allowed free movement within their own environment.

a. During afternoon observations at the day program on 4/9/18, client #8 was verbally prompted to enter a room where other clients were exercising. Client #8 entered the room, stood looking at the staff and then proceeded to exit the room. The staff person, took hold of client #8's right forearm and then pulled him back into the room by holding onto his belt. Further observations revealed the staff person standing in front of client #8 while he again made an attempt to exit the room.

During an interview on 4/10/18, staff revealed client #8 can have free movement within his environment.

Review on 4/10/18 of client #8's IPP dated 2/13/18 stated, "He...capable of moving about as he wishes".

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W 249	Continued From page 5 During an interview on 4/10/18, the qualified intellectual disabilities professional (QIDP) confirmed staff should have held onto client #8's belt as he was attempting to exit the exercise room at the day program. b. During morning observations in House #2 on 4/10/18, client #1 exited her bedroom, came out into the hallway and stood next to the surveyor. A staff person then exited another clients' bedroom, saw client #1 standing in the hallway and called out to another staff (who was in the kitchen) and asked was breakfast ready. The staff in the kitchen replied "No". Client #1 was then physically walked back into her bedroom and told to stay there. During an immediate interview, the staff said, "[Client #1] is suppose to be sitting in her room, until staff are ready for her to come up front". When further asked if client #1 can make her own choices, the staff told the surveyor to go ask [QIDP's name]. Review on 4/10/18 of client #1's IPP dated 11/7/17 revealed, "Enjoys moving around freely...." During an interview on 4/10/18, the QIDP revealed client #1 can make her own choices and staff know she can make choices. 2. Client #7's diet consistency was not follow as written. During lunch observations at the day program on 4/9/18, client #7 was observed consuming Cheetos Crunch Cheese flavored snack. Further	W 249		

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W 249	Continued From page 6 observation revealed the Cheetos ranged in size from 1/2 to 2 inches in length. While consuming the Cheetos client #7 coughed 2 times. At no time where the Cheetos broken into pieces. During dinner observations in the home on 4/9/18, client #7 was observed consuming a mixture of rice, mixed vegetables, and chunks of chicken. The mixed vegetables consisted of pieces of baby corn which were 1/2 inch in length. The pieces of chicken ranged in the size from 1/2/ to 2 inches in length. While consuming the mixture client #7 coughed 3 times. At no time was client #7 prompted to cut her food. Review on 4/9/18 of the SCI-Coastal House II Diet Chart dated 3/24/18 located on the refrigerator stated, "[Client #7]: consistency: Chopped". Review of client #7's IPP dated 12/5/17 indicated, "...regular chopped diet...." Client #7's nutritional evaluation dated 3/9/18 revealed her diet is chopped. The physician orders signed 3/8/18 revealed, "...Chopped Diet". During an interview on 4/10/18, the QIDP reported client #7's food should be the size of a pea. Further interview revealed staff have been "informed" about client #7's diet consistency.	W 249		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the	W 322		

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W 322	Continued From page 7 facility failed to ensure 2 of 5 audit clients (#2, #5) received preventive recommendations. The findings are: 1. Client #2 has not received her annual mammogram. Review on 4/10/18 of client #2's nursing evaulation dated 4/25/17 indicated she received a mammogram on 7/13/16 with the recommendation to return in one year. Further reveiw revealed client #2 had not received a mammogram in 2017. During an interview on 4/10/18, the facility's nurse confirmed client #2 did not return in a year for her annual mammogram. 2. Client #5 was not provided with ACT mouthrinse which was recommended by the dentist. Review on 4/10/18 of client #5's dental examination dated 4/9/18 stated, "Fluoride Rinse ACT 1 or 2x day after brushing, especially before bed". During an interview on 4/10/18, staff said, "I think [Client #7] uses the rinse during medication pass". During an interview on 4/10/18, the facility's nurse revealed client #7 did not have the ACT Rinse. The nurse stated, "Yesterday was busy" and no one was able to purchase the rinse.	W 322		
W 325	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii)	W 325		

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W 325	Continued From page 8 The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure routine screenings were obtained for 1 of 5 audit clients (#8). The finding is: A routine screening for client #8 was not obtained. Review on 4/19/18 of client #8's record revealed he was scheduled for a colonoscopy on 11/20/17; but it was cancelled to due to him becoming ill and being admitted to the hospital. Further review client #8 was not rescheduled for another colonoscopy. Further review revealed client #8 is 52 years old. Review on 4/10/18 of the faclity's policy on diagnostic screening schedules (reviewed 10/2013) revealed, "Colon and Rectal Cancer Screening: 1. Beginning at the age of 50 men...at average risk for developing colorectal cancer should use one of the screening rests below. The tests that are designed to find both early cancer and polyps are preferred of these tests are available: Tests that find both polyps abd cancer:...Colonoscopy every 10 years...." During an interview on 4/10/18, the facility's nurse revealed there was no documentation regarding the rescheduling of client #8's colonoscopy or information regarding the guardian declining the procedure.	W 325		

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W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#2) received nursing services in accordance with her medical needs. The finding is: Client #2 did not receive nursing services in accordance with her health needs. Review on 4/10/18 of client #2's record revealed a "Monthly Breast Exams" sheet. Further review revealed client #2's breasts are to be checked each month for the following: lymph nodules, nipple drainage, inverted nipples and lumps or masses. Client #2's breasts were last checked 2/2018. Further review there was no data for the month of March 2018. During an interview on 4/10/18, the facility's nurse confirmed client #2's breast examination had not occured in March 2018.	W 331		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 336		

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W 336	Continued From page 10 failed to ensure 1 of 5 audit clients (#2) received a review of their health status at least quarterly. The finding is: Nursing assessment was not completed at least quarterly for client #2. During a review on 4/10/18 of client #2's record revealed her last nursing quarterly was conducted on 3/2016. No other assessments could be located. During an interview on 4/10/18, the facility's nurse revealed he was aware of the missing quarterlies for client #2.	W 336		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #2 received an annual comprehensive dental examination for the maintenance of her oral health. This affected 1 of 5 audit clients. The finding is: Client #2 did not have dental cleaning at least annually. Review on 4/10/18 revealed client #2 last received a dental cleaning on 8/22/16. Further review indicated client #2 no other dental examinations.	W 352		

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W 352	Continued From page 11 During an interview on 4/10/18, the facility's nurse revealed client #2 had two follow-up dental examinations scheduled for 6/28/17 and 8/24/17, but due to client behaviors those examinations were not conducted. The nurse confrmed no other dental appointments had been scheduled.	W 352		
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, policy review and interview, the facility failed to ensure all drugs and biologicals remained locked. This affected all the clients residing in House #1. The finding is: The medications were left unsecured and unsupervised by the facility nurse. During morning medication administration in House #1 on 4/10/18 at 7:29am, the facility nurse went around the corner from the medication closet to hand client #2 her medications; which were in a plastic medication cup. The nurse stood there for 5 minutes while client #2 swallowed her pills one at a time. Further observations revealed staff and other clients going up and down the hallway, while the door remained open. Additional observations revealed the cabinets inside of the medication room were unlocked and open. At no time during was the door to the medication room closed.	W 382		

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W 382	Continued From page 12 Review on 4/10/18 of the facility's medication administration policy (revised 9/17) stated, ..."Procedure: 4. Medication cabinets/clostes are locked at all times except during medication preparation...." During an interview on 4/10/18, the facility nurse confirmed the door to medication closet should have been closed, while he observed client #2 consuming her medications.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure an electric toothbrush was purchased for client #5. The finding is: Client #5 was not provided with an electric toothbrush as recommended by the dentist. Review on 4/10/18 of client #5's dental examination dated 4/9/18 stated, "...Electric toothbrush would be ideal". Further review revealed client #5's dental rating to be "POOR". During an interview on 4/10/18, staff showed the surveyor client #5's manual toothbrush. The staff	W 436		

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W 436	Continued From page 13 revealed the bristles of client #5's toothbrush were worn down. During an interview on 4/10/18, the qualified intellectual disabilities professional (QIDP) confirmed client #5's manual toothbrush bristles were worn and needed to be replaced. During an interview on 4/10/18, the facility's nurse revealed the electric toothbrush recommended for client #5 should have been purchased.	W 436		