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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 paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.	E 036		

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 036	Continued From page 1 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to develop a emergency preparedness (EP) training and testing program. The finding is: The facility failed to develop an emergency preparedness training and testing program. Review on 7/16/18 of facility's EP manual did not include any information on training or testing of the facility's staff. Staff (1) interview in the home on 2/5/18, concerning the EP plan revealed the following information, "They would ensure all clients were out of the home and safe even if they were only able to ride on the van." During an interview on 7/17/18, the executive director revealed there had been training however no documentation was available.	E 036		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] 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 the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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procedures.
*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] 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 arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency 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.
(iii) Provide emergency preparedness training at least annually.
(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.

*[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

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arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[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 arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(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.

*[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 annually.
(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

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their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[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 annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must 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, 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 annually.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure direct care staff were sufficiently trained on the facility's emergency plan (EP). The

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E 037	Continued From page 5 finding is: Staff had not received adequate training on the emergency plan (EP). Review on 7/17/18, of the facility documents revealed training inservice sheets for direct care staff in regards to disaster drills. Staff interviews (2) on 7/17/18 revealed the following; staff were able to provide the procedures regarding fire drills and disaster drills; however, the staff could not provide specific details regarding any training they received for the facility's EP program. Interview on 7/17/18, with the executive director (ED) revealed she did not have any documented training available for direct care staff specific to the facility's EP.	E 037		
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 record review and interview, the facility failed to ensure client #6 had a legal guardian. This affected 1 of 4 audit clients. The finding is: Client #6 has no documentation of a legal guardian. Review on 7/17/18 of client #6's record revealed	W 125		

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W 125	Continued From page 6 no documentation to confirm he has a legal guardian. Interview on 7/17/17 with the executive director (ED) confirmed client #6's has no documentation to confirm he has a legal guardian. However, the ED explained the paperwork had been filed just not received by them at this time.	W 125		
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the individual program plan (IPP) for 1 of 4 audit clients (#6) was provided to all relevant staff (day program). The finding is: During interviews on 7/16/18, management at the day program confirmed the facility has provided them with the clients' individual program plans (IPP) and the behavior support plans (BSP). Review on 7/16/18, of the IPPs and BSPs at the day program revealed an IPP dated 3/22/17, for client #6. During an interview on 7/16/18, the qualified intellectual disabilities professional (QIDP) stated she thought the day program had all updated	W 248		

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W 248	Continued From page 7 copies of the client's IPP and BSP.	W 248		
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, interviews and record review, the facility failed to enusre 3 of 4 audit clients (#2, #3 and #4) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the area of medication administration participation. The findings are: 1. Client #2 was not afforded the opportunity to consistently display his independence with self medication administration. During observations on 7/16/18 of client #2's medication administration pass at approximately 4:34 pm, client #2, entered the medication room and sat in a chair. The medication technician gave him the hand sanitizer, removed his medications from the medication closet, ran his water and assisted him in punching his medication. Client #2, took his medication independently and disposed of his trash and left	W 249		

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the medication room.

Review on 7/17/18 of client #2's self-administration medication assessment dated 6/27/18, revealed client #2, is capable of the following, washing his hands, obtaining proper medication cup, recognize his name, locating his medication basket and returning his medication container to the proper location.

During an interview on 7/17/18, with management confirmed client #2, should have been allowed to perform as much of his medication administration as independently as possible.

2. Client #3 was not afforded the opportunity to consistently display his independence with self medication administration.

During observations on 7/16/18 of client #3's medication administration pass at approximately 4:40pm, client #3, entered the medication room and sat in a chair. The medication technician gave him the hand sanitizer, removed his medications from the medication closet, ran his water and assisted him in punching his medication. Client #3, took his medication independently and disposed of his trash and left the medication room.

Review on 7/17/18 of client #3's self-administration medication assessment dated 11/22/17, revealed client #3, is capable of the following, washing his hands, obtaining proper medication cup, recognize his name, locating his medication basket and returning his medication container to the proper location.

During an interview on 7/17/18, with management

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W 249	Continued From page 9 confirmed client #3, should have been allowed to perform as much of his medication administration as independently as possible. 3. Client #4's medication administration objective was implemented as written. During observations on 7/16/18 of client #4's medication administration pass at approximately 4:50 pm, client #4, entered the medication room and sat in a chair. The medication technician gave him the hand sanitizer, removed his medications from the medication closet, ran his water and assisted him in punching his medication. Client #4, took his medication independently and disposed of his trash and left the medication room. Record review on 7/17/18 of client #4's medication administration objective revealed the following, "[Client #4] will complete/assist in the process of the medication administration process with 50%, participation for 6 months. Methods/instructions staff will provide [Client #4] an opportunity to work towards independence with medication administration. Staff should make material accessible to [Client #4]. Staff should teach, monitor, and model for [Client #4] as needed to assist with the completion of the medication process." At no time was staff observed teaching, monitoring or modeling for client #4. During an interview on 7/17/18, with management confirmed client #4's, medication administration objective should have been implemented as written.	W 249		
W 252	PROGRAM DOCUMENTATION	W 252		

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W 252	Continued From page 10 CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure objective data relative to the accomplishment of specified criteria was documented. This affected 1 of 4 audit clients (#6). The finding is: Data was not collected as indicated for client #6. During review of client #6's data book revealed an objective for money management and data should be collected 5 times per week according to schedule. The data was collected on the following date 7/5/18, and no other data was available. During an interview on 7/17/18, with management staff confirmed data for client #6's money management objective should be collected as it written in his objective.	W 252		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by:	W 369		

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W 369	Continued From page 11 Based on observations and interviews, the facility failed to ensure all medications were administered without error for 1 of 4 audit clients (#4). The finding is: Client #4's medications were not administered without error. During observations of medication administration in the home on 7/16/18 at approximately 4:43 pm, client #4 received Polyethylene Glycol 3350 in 4 ounces of waters. During an interview on 7/16/18, the medication technician revealed client #4's, Polyethylene Glycol bottle gave the instructions of 4 to 8 ounces of water and he was following these instructions. Review on 7/16/18, of client #4's physician orders revealed, "Polyethylene Glycol 3350 dissolve 1 cap (17 grams) and mix in 8 0z. of water or fluid and drink." During an interview on 7/17/18, with management revealed client 4's medication should have been given according to the physicians order.	W 369		
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.	W 436		

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W 436	Continued From page 12 This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to furnish and maintain in good repair a dining table chair this affected all clients. The finding is: The right side of the back support of a dining table chair was broken. Upon entering the home on 7/16/18, a dining table chair was observed to have the right side of the back support broken. During all meals and snacks observed throughout the survey the clients utilized this chair to sit at the dining table. Interview on 7/17/18, with staff (1) revealed the chair had been broken for at least 3 weeks. Interview on 7/17/18, with management revealed they were not aware of the broken chair and had not been informed of it by staff.	W 436		