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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 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.	E 037	All staff including direct care staff will receive training on the emergency preparedness policies and procedures. within the next 30 days. An emphasis on all specific details regarding the emergency preparedness plan will be emphasized with a mini quiz as part of the training to assure staff knowledge/comprehension and skilled to follow through with the emergency preparedness during a crisis. Training will be provided annually for all existing staff. All emergency preparedness training will be documented for best practice as well as evidence based for staff training. The Director and/or Program Director will monitor the emergency preparedness training as well as all required training at least quarterly to assure that all staff training is current. DHSR - Mental Health AUG 24 2018 Lic. & Cert. Section	9-28-18

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

[signature] Chief Operations Officer 8-21-2018

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 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 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.	E 037		

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E 037	Continued From page 2 *[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 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	E 037		

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E 037	Continued From page 3 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 interviews and record review, the facility failed to assure direct care staff were adequately trained on the facility's emergency preparedness policies and procedures. This potentially affected all clients residing in the facility. The finding is: Staff were not adequately trained on the facility's emergency preparedness plans. During an interview on 7/30/18, staff A revealed he had not received any training on the facility's emergency preparedness plans. He stated he is only works part time. Management staff confirmed, in an interview on 7/30/18, that staff A was not trained on emergency preparedness. During an interview on 7/30/18, staff B revealed she had not received any training on the facility's emergency preparedness plans and had to find another staff to know where to go to evacuate the clients from the building. During an interview on 7/30/18, staff C revealed she had not received any training on the facility's	E 037		

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E 037	Continued From page 4 emergency preparedness plans. The other staff interviewed further stated they had recently received information about the emergency preparedness plans but could not answer detailed questions. During an interview on 7/30/18, management revealed one inservice sheet dated 6/26/18 which she stated was all the staff who were trained. She also confirmed staff A's name was not listed and staff C's name was listed. She acknowledged they are still working on their emergency preparedness plan training and confirmed staff takes more training to remember. Review on 7/30/18 of facility's emergency preparedness plans revealed no documentation of testing to indicate the facility had conducted any assurance that the emergency preparedness training was comprehended.	E 037		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to assure 2 of 5 audit clients (#5 and #7's) individual program plan (IPP) included specific instructions to support their independence in wearing prescription eye glasses and wheelchair positioning protocol. The findings are:	W 240	A core team meeting will be held to fully develop plans for determining the level of support needed for client #7 wearing his eye glasses. The attending medical provider that completed client #7 eye examination will be contacted for clarification regarding recommended schedule for wearing his eyeglasses. A service goal/goal will be developed as deemed appropriate by the team with a focus on increasing Client #7 independence in wearing his eye glasses.	9-24-18

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W 240	Continued From page 5 Client #7 was not consistently encouraged to wear his eye glasses. During observations in the home on 7/30/18, client #7 was not wearing his eye glasses. Client #7 was not observed wearing his eye glasses until he was eating his dessert during lunch. Client #7 was not observed to be consistently wearing nor prompted to wear his eye glasses throughout the survey. During observations in the home on 7/30/18, client #7 was not observed wearing his eye glasses he was engaged in activities such as watching the Price Is Right on the television, meal preparation see, touch and feel items and story time see, touch and feel items in the book which staff were reading to the clients'. Staff did not consistently offer nor assist client #7 with putting on his eye glasses. Review on 7/30/18 of client #7's physical examination dated 4/10/18 revealed a need for eye glasses. The examination did not reveal a schedule for wearing his eye glasses or his independence. Further review of the IPP dated 5/8/18 did not identify his eye glasses use or any instructions to support his independence in wearing his eye glasses. During an interview on 7/31/18, the qualified intellectual disabilities professional (QIDP) confirmed she did not include information about client #7's eye glasses nor the use of his eye glasses. Further interview confirmed client #7 was not currently receiving any training on the use of his eye glasses and training could be tried with him.	W 240	cont. All client's wearing eye glasses needs will be assessed. Goals/service goals will be developed as deemed appropriate by the team. All staff will receive training on goals/service goals developed. Client #5 positioning in his wheelchair will be reassessed by the physical therapist with documentation that clearly outlines the appropriate positioning protocol for Client #5 wheelchair as well as marking and/or indicators to identify the appropriate measurement guide/indicator that identify the proper angle/elevation of client #5 wheelchair during mealtimes (47-S) and during all other activities to assure the correct positioning in his wheelchair is clearly outlined as well. All staff will be trained on client #5 positioning in wheelchair protocol. Additional core team meetings & /or staff training will occur as needed for positioning for all client's in their wheelchairs. The Director/QP or the Program Director will monitor the positioning of client #5 wheelchair during meals at least 5 times the first week of implementation	

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W 240	Continued From page 6 2. Client #5's wheelchair positioning instructions were not written to be easily followed. During breakfast observations in the home on 7/30/18 at 9:09am, client #5 was positioned at the dining table with the head of his wheelchair tilted upwards and foot block padding touching the table. During lunch observations in the home on 7/30/18 at 12:48a, client 5 was positioned client #5 was positioned at the dining table with the head of his wheelchair tilted slightly upwards and foot block padding was well under the tablet. During an interview on 7/30/18, the staff assisting client #5 with his lunch revealed she did not know exactly where to position client #5's wheelchair. She further stated there used to be marks as indicators on his wheelchair, but they have changed it and they are no longer there. During observations on 7/30/18 of client #5's wheelchair bed there were not any markings nor measurement guide/indicator to identify the proper angle elevation alignment(s). During an interview on 7/31/18, a staff stated it was confusing as to what angle and what degrees client #5 is to be positioned. Further interview revealed, [Client #5's] elevation 35 degrees meal times and 40 degrees at bed time (in his real bed)." Review on 7/31/18 of client #5's wheelchair positioning protocol dated 7/28/13 (revised) revealed, "III. Positioning Procedures: ...2. Place small pillow between the ankles and knees for comfort. 3. All staff should position themselves	W 240	Cont. following clarification and at least twice per week thereafter.	

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W 240	Continued From page 7 to [Client #5's] right side and his chair should be positioned so that all activities are to his right side. This should be done to decrease trunk position from turning to his left side. 4. The angle of the flat bed is fixed so to provide the proper elevation (for breathing and oral motor control) during meals (prevent reflux and proper digestion)...." Review on 7/31/18 of client #5's 47-S mealtime protocol dated 2/3/13 (revised) revealed, "II. Positioning: [Client #5] should be placed in his seating system with seatbelt fastened. The seating system (flatbed) should be elevated (at least 35 degrees) so that he is not lying flat while eating or drinking (swallowing and reflux precautions). Due to recent changes with the bed (purchased a hospital bed) it can also be as a positioning area for feeding [Client #5]. The bed needs to be at a 40 degree angle (there is a mark on the frame where angle of bed needs to be). Also prior to feeding [Client #5] staff needs to make sure to correctly positioning him if he has slid down in bed...." During an interview on 7/30/18, the QIDP/director confirmed there were no markings to indicate the angles/degrees client #5 should be positioned. She further stated there used to be markings, but changes had been made and she thought the flat wheelchair bed was to stop at the level needed only if positioned to that point. Additional interview confirmed there needs to be clear directions and some type of indicators to identify the correct positioning angles.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 8 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 reviews, the facility failed to assure interactions with all clients supported the implementation of the individual program plan (IPP) specifically in the area of self-medication administration. This affected 1 of 5 audit clients (#1). The finding is: Client #1's service goal was not consistently implemented as written. Observations on 7/30/18, at 7:23am, client #1 was only encouraged to open her hand to receive her medications from her medication cup during the morning medication pass. Client #1 was not offered nor encouraged to participate in her medication administration. Review of client #1's record on 7/30/18 revealed an IPP dated 3/20/18. This indicated she needs assistance with medication administration but did not indicate a detailed assessment of her skills or potential. However, further review revealed a service goal noting she should come to the medication room when notified; wiped her hands with prompts; choose and pour her beverage; place meds in mouth and swallow and throw her trash away.	W 249	Interim core team meeting will be held to review client #1 medication administration skills. Client #1medication administration skills will be reassessed by the RN Team Lead as deemed appropriate by the team. Based on the outcome of the assessment, client #1 service goal and nursing care plan will be updated to reflect needed changes to maximize independence in her self- medication administration skills. All medication monitors and nurses will be in-serviced by the RN Team Lead on the revised and/or new service goal. All clients' self-medication administration skills will be reassessed as needed to assure that strategies outlined continues to meet their needs with update/revision as deemed appropriate by the team to increase their independence. All medication monitors and nurses will be in-service on all services updated and/or revised by the RN Team lead. The Director/QP will monitor at least twice per week and the RN Team Lead will monitor at least monthly.	9-28-18

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W 249	Continued From page 9 Interview on 7/30/18 and 7/31/18 with the nurse revealed he did not realize the list on the service goal was there until looking for an assessment for the surveyor. He said, he did some of the tasks for her because of her dementia and failure to do them now. He also indicated, that due to this dementia and her regression, he is sure she would need to be assessed again based on the current service goal list and her current skill ability.	W 249		
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, interviews and record reviews, the facility failed to assure all clients were taught to administer medications through the use of a valid assessment of their skills and potential. This affected 1 of 5 audit clients (#1). The finding is: Client #1 was not assessed to be trained to administer her own medications as needed. During observations on 7/30/18 of the medication pass at 7:23am, client #1 was only encouraged to open her hand to receive her medications from her medication cup. Client #1 was not offered nor encouraged to participate in her medication	W 371	Client #1 and all clients will be reassessed for Self Administrations of Medications and core team meetings held to assure that an appropriate and valid assessment of their skills are utilized to determine how to best meet their needs for Self Administration of Medications. Any objective established for training in self-administration of medication will be included in the PCP. All medication monitors and nurses will be in-serviced. Additionally, all clients will be assessed to determine if training in self-administration of medications is beneficial to the individual. In the future, all clients will have another assessment completed anytime their needs change and deemed appropriate by the team. The RN Team Lead will monitor monthly and the Director will monitor at least quarterly.	9-28-18

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W 371	Continued From page 10 administration. Review of client #1's record on 7/30/18 revealed an individual program plan (IPP) dated 3/20/18. This indicated she needs assistance with medication administration but did not indicate her skills or potential. However, further review revealed a service goal noting, she should come to the medication room when notified; wiped her hands with prompts; choose and pour her beverage; place meds in mouth and swallow and throw her trash away. Further review of the record on 7/31/18 revealed no assessment of her medication administration assessment. Interview on 7/30/18 and 7/31/18 with the nurse revealed he did not realize the list on the service goal was there until looking for an assessment for the surveyor. He also indicated when asked twice, he did not have a documented assessment for self-medication administration. He also indicated, that due to her dementia, she has regressed and he is sure she would need to be assessed again based on the current service goal list. He stated she cannot throw away items or pour on some days.	W 371		
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	Client #1 will be provided eyeglasses as identified by the interdisciplinary team as soon as possible. A core meeting will also be held to determine client #1 need for training on eyeglasses care. A goal and/or service goal will be developed as determined appropriate by the team. A core meeting will also be held for Client #7 regarding training on wearing his eye glasses. If determined appropriate by the team a goal	9-28-18

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W 436	Continued From page 11 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure all adaptive equipment was provided by the facility and that individuals were trained to use and care for their equipment (specifically eyeglasses). This affected 2 of 5 audit clients (#1 and #7). The findings are: 1. Client #1 was not provided with eyeglasses in good condition or trained on eyeglass care. During observations on 7/30 and 7/31/18, client #1 was not provided with eyeglasses. Review of client #1's individual program plan (IPP) dated 3/20/18 revealed her vision is impaired and she has eyeglasses. Interview with staff on 7/30/18 revealed client #1's eyeglasses are broken. Further interview with the qualified intellectual disability professional (QIDP) on 7/31/18 revealed that client #1's eyeglasses are broken. She also indicated that client #1 has a new prescription and that the glasses are being made at "Walmart Vision Center" because the eye doctor that prescribed her glasses is too expensive. The QIDP was asked who pays for the glasses and she indicated the facility does not provide glasses to client #1 because she breaks them so frequently that Medicaid won't cover them. She also indicated that the client has not had a goal to learn to stop breaking her glasses. Further interview with the QIDP on 7/31/18 revealed that the guardian consent is not required	W 436	Cont. and/or service goal will be developed to increase client #7 wearing his eyeglasses. In the future, service goals will be developed as soon as a need for equipment such as eyeglasses is made known as well as identified training warrant in assisting client in taking care of their equipment. This procedure will assure that all clients' needs for adaptive equipment (eyeglasses etc.) will not be overlooked. Further, the QP will maintain a list of needed equipment / needed equipment repairs / or modifications that will be assessed at least quarterly for needed follow-up. Interim QP notes will be entered in the client record as needed. The Director/QP will monitor at least Monthly and the assigned Executive Director will monitor at least quarterly.	

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(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
W 436	Continued From page 12 for the purchase of her new glasses because they are projected to be under $100.00 which is the limit for no consent required per the company wide policy. She was then asked to present the policy. Review of the company wide policy on 7/31/18 indicated a revision date of 2-23-10 and revealed what the client should pay for and what the facility should pay for. The items revealed that eyesglasses and repairs not covered by Medicaid should be paid for by the client. The policy further noted that non-routine items over one hundred dollars in one shopping trip should be approved by the Chief Operating officer, "COO." The policy does not require guardian consent. Interview with the QIDP on 7/31/18 after review of the policy indicated approval must come from guardian as well as the "COO" for items over $100.00. 2. Client #7 did not wear consistently wear his eye glasses. During morning observations in the home on 7/30/2018, client #7 was not observed wearing eye glasses nor was he offered or encouraged to wear any eye glasses. Client #7 was not offered to wear his eye glasses until afternoon, while he was preparing to eat his lunch dessert. Record review on 7/31/18 of client #7's physical examination dated 4/10/18 revealed "Eye glasses."	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G040	A. BUILDING _____ B. WING _____	07/31/2018

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W 436	Continued From page 13 During an interview on 7/30/18, a staff revealed client #7 is to wear his eye glasses all the time, but he does not like to wear them all the time. During an interview on 7/31/18, the QIDP confirmed client #7 has eye glasses and he should have been wearing them. Further interview revealed client #7 was currently not receiving any training on the use of his eye glasses and training could be tried with him.	W 436		
W 454	INFECTION CONTROL CFR(s): 483.470(I)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure a sanitary environment was provided to avoid transmission of infections and prevent possible cross-contamination. This potentially affected all clients residing in the home. The findings are: Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination. During dinner meal preparation observations in the home on 7/30/18 at 6:17pm, staff wore gloves while she used a disinfectant wipe to wipe the dining table. The staff continued to wear the same gloves while she transported a client in a wheelchair to wash their hands. The staff continued to wear the gloves while she assisted the client to obtain clothing protectors, assisted the client with placing the clothing protectors on	W 454	All personnel will receive training in: • infection control and the spread of infection • Providing a sanitary environment • Glove usage and disposal • Precautions to promote a healthy environment and prevent cross contamination The Program Director and / or the Director will monitor at least three times a week for 30 days, with retraining and reminders provided as needed and then twice a week ongoing.	9-28-18

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W 454	Continued From page 14 the table for the clients and to place napkins on the table for each client. The staff did not remove the dirty gloves until after she had completed all of the tasks. During an interview on 7/30/18, the staff stated they thought the gloves were clean. Since they assisted the client with using an antibacterial wipe to clean the client's hands, then the gloves she was wearing were then cleaned. The staff revealed they are to wear gloves during changing clients and changing bibs and they are to be changed before assisting another client. Further interview revealed, "Yes, I guess I should have changed gloves. I didn't." During an interview on 7/30/18, the qualified intellectual disabilities professional (QIDP) confirmed the staff should have not have worn the same gloves as used for cleaning to assist a client with hand washing and setting the table. The gloves should have been removed after cleaning the table.	W 454		
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, interviews and record review, the facility failed to assure 1 of 5 audit clients (#10) received their prescribed. The finding is: Client #10 did not receive his prescribed	W 460	All staff assisting clients during meals will receive training on assuring that client #10 and all clients receives a nourishing well balanced diet during all meals. Special emphasis will be placed on all clients receiving their prescribed diet which will include supplements and substitutions when they refused what is currently being served on the menu. All staff will also be re-in serviced on client #10 service goal 45-S food substitution/refusal plan outlining specific instructions even if he refuses the alternate food choices with notification to the appropriate individuals to follow up as needed. Staff will be in service on all clients' food/substitution plans. The Director/QP and the Program Director will monitor at least two times weekly.	9-22-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 460	Continued From page 15 supplement. During lunch observations in the home on 7/30/18 at 1:18pm, client #10 was offered creamed potatoes, beets, tuna, crackers, chocolate ice cream and beverages of tea and water. Client #10 refused his main lunch meal. However, he did eat all of his dessert of chocolate ice cream. He did drink some of his tea. There were no other foods or beverages offered to client #10 after he eat his ice cream. During an interview on 7/30/18, a kitchen staff revealed there is a food substitution list and Ensure Plus available to client #10; however, staff would have to let the kitchen staff know when they need a meal substitution. Further interview revealed there is always Ensure Plus in the refrigerator which client #10 can have. Review on 7/31/18 of client #10's 45-S food substitution /refusal plan dated 9/5/12 revealed, "If the client refuses a food item a substitute will be offered that is from the same food group....If the client refuses a meal an alternate meal will be offered from the cabinet, or 8oz. of Ensure Plus. If the client refuses the alternate choice the Nurse and/or the Director will be notified...." During an interview on 7/30/18, the qualified intellectual disabilities professional (QIDP)/ director confirmed staff should have documented the meal refusal and offered a meal substitution or offered Ensure Plus, none which were done. She further confirmed client #10's food substitution /refusal plan dated 9/5/12 was current and should have been followed.	W 460		