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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The finding is: The facility's EP plan was not reviewed or updated annually.	E 004	E 004 – The facility will ensure the Emergency Preparedness Plan is reviewed and updated at least annually. Management team will review the Emergency Preparedness Plan and make changes/revisions as needed. QP will monitor annually.	3-9-19 3-9-19

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

Chris Smith, IPF Division Director — 2-1-19

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 004	Continued From page 1 Review on 1/7/19 of the facility's EP plan revealed no date. Further review of the plan did not include evidence of an annual review or update. Interview on 1/8/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was not aware if the EP plan had been reviewed or updated annually and an updated plan had been requested from management staff several months ago.	E 004		
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.	E 037	E 037 – The facility will ensure that all staff members are trained on the facility's Emergency Preparedness Plan.	3-9-19

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E 037	Continued From page 2 (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 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:	E 037		

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E 037	Continued From page 3 (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 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,	E 037		

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E 037	Continued From page 4 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 record review and interviews, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Staff had not been trained on the facility's EP plan. Review on 1/7/19 of the facility's EP plan (no date) did not include any information regarding training of staff. Staff interviews (2) on 1/7 - 1/8/19 revealed they had been trained on conducting fire drills;	E 037	QP will inservice all staff members on the facility's Emergency Preparedness Plan. QP and Program Manager will monitor monthly.	3-9-19

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E 037	Continued From page 5 however, the staff could not provide specific information regarding the facility's EP plan. During an interview on 1/8/19, the Qualified Intellectual Disabilities Professional (QIDP) revealed there was no documentation to indicate if or when staff had been trained on the facility's EP plan.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based.	E 039	E 039 – Management staff will ensure that a facility/community-based or tabletop exercise is conducted to test the emergency plan.	5-9-19

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E 039	Continued From page 6 (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise.	E 039	QP and Program manager will complete a tabletop exercise to test the current emergency plan. QP and Program Manager will monitor monthly.	3-9-19

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E 039	Continued From page 7 Review on 1/7/19 of the facility's EP plan (no date) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 1/8/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 039		
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: Based on observations, interviews and record review, the facility failed to ensure staff were sufficiently trained to perform their medication administration duties. The findings are: Proper medication administration procedures were not followed. During observations of medication administration in the home on 1/7/19 at 4:16pm and on 1/8/19 from 7:24am - 7:25am, the medication technicians (MT) assisted clients with dispensing and consuming their medications. The MT utilized a computer to pull up each client's morning medications. Before the clients consumed their pills, the MT signed off on each	W 189	189 – The facility will ensure that all staff members are sufficiently trained to perform their medication administration duties. Nursing staff will inservice all Med Tech's on medication administration protocol. Nursing staff and Program Manager will monitor weekly. QP will monitor monthly.	3-9-19

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W 189	Continued From page 8 drug (signified by a large green check mark) using the computerized system. Immediate interview with both MT's revealed the when using the computerized system a green check mark indicates the medication has been given and is equivalent to signing the Medication Administration Record (MAR). Interview on 1/8/19 with the QIDP confirmed med techs should wait for clients to consume their medications before signing off on the computerized MAR.	W 189		
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, record reviews and interviews, the facility failed to ensure 3 of 3 audit clients (#1, #2, #4) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation, family style dining, participation with medication administration, diets, meal guidelines and self-help skills. The findings are:	W 249	W249 – The facility will ensue that all individuals receive continuous active treatment plan consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objective identified in the IPP.	3-9-19

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W 249	Continued From page 9 1. Clients were not actively involved in meal preparation at dinner and breakfast. During evening observations in the home on 1/7/19 from 4:30pm - 5:40pm, staff completed various cooking tasks including obtaining food/cooking items, cutting sausages, peppers, onions and cabbage, cooking all food items on the stove top, operating the microwave, and placing food into serving dishes. During this time, client #2 and another client placed cut up food items into a pan. During morning observations in the home on 1/8/19 from 7:33am - 7:50am, staff completed all cooking tasks including preparing pancakes and scrambled eggs without any client involvement. Staff interview on 1/8/19 revealed another staff who normally does meal preparation was running late so they just decided to cook the meal. When asked if any clients participate with cooking tasks, the staff stated, "I don't to much let them mess with the stove." Additional interview indicated the clients can participate in stirring, cutting and other tasks. Review on 1/8/19 of client #1's IPP dated 9/6/18 revealed he should continue to be offered opportunities to participate in meal preparation. The plan also identified a need to improve home living skills. Additional review of the client's Adaptive Behavior Inventory (ABI) dated 8/8/18 indicated he can operate the oven and burners on an electric stove, prepare a breakfast meal with partial independence. The ABI noted the client uses kitchen equipment and prepares beverages independently.	W 249	1. QP will inservice all staff members on client#2's kitchen/mealtime strengths to ensure sufficient participation during meal prep. QP and Program Manager will monitor weekly.	3-9-19

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W 249	Continued From page 10 Review of client #2's IPP dated 1/4/18 revealed a need to increase independence in home living skills. Additional review of the client's ABI dated 828/18 revealed she can prepare sandwiches, salads and desserts, use kitchen equipment, and prepare beverages with partial independence. Further review of the ABI noted she can independently prepare convenience foods. Interview on 1/8/19 with the QIDP confirmed clients in the home can assist with various cooking tasks given assistance as needed. 2. Clients were not prompted or assisted to participate with medication administration to their maximum potential. a. During observations of medication administration in the home on 1/8/19 at 7:24am, client #2 participated with the administration of her medications by coming to the area, pouring her water and ingesting her pills independently. The staff retrieved the medications, placed them in a pill cup and threw away trash. Review on 1/8/19 of client #2's ABI dated 8/28/18 revealed the client can independently come to the area, take her pills with water, and punch pills from a pill card. b. During observations of medication administration in the home on 1/8/19 at 7:26am, client #1 participated with the administration of his medication by coming to the area, pouring his water, and throwing away his trash. The staff retrieved the medications and placed them in a pill cup. Review on 1/8/19 of client #1's ABI dated 8/8/18	W 249	2a. QP will inservice all staff members on client#2's medication administration strengths to ensure adequate participation during medication administration. QP, Nursing and Program Manager will monitor weekly. 2b. QP will inservice all staff members on client#1's medication administration strengths to ensure adequate participation during medication administration. QP, Nursing and Program Manager will monitor weekly.	3-9-19 3-9-19

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W 249	Continued From page 11 revealed he can independently come to the area and take his pills with water. The ABI noted "no independence" with punching his pills from a pill card. Interview with the medication technician on 1/8/19 revealed clients do not assist with placing pills in pill cups because "they might drop them." Interview on 1/8/19 with the QIDP revealed client #1 and client #2 can participate with various aspects of medication administration including placing their pills in a pill cup given assistance. 3. Clients were not prompted or assisted to participate with all aspects of family style dining and other dining skills. During dinner observations in the home on 1/7/19 at 5:43pm, staff walked around the dining room table carrying serving bowls and pitchers to each client. Clients were not prompted or assisted to pass serving bowls and pitchers. During breakfast observations in the home on 1/8/19 at 7:50am, staff walked around the dining room table carrying serving bowls and pitchers to each client. Staff also poured drinks for the clients. Later, during the meal, a staff cut up pancakes for each client. Clients were not prompted or assisted to participate with these tasks. Staff interviews (2) on 1/8/19 revealed clients usually pass serving bowls and pitchers at meals and can pour their own drinks. Additional interview indicated the clients could have assisted with cutting their pancakes but she "didn't want to disturb them" while they were eating.	W 249	3. QP and Program Manager will inservice all staff members on all aspects of family style dining and how to involve client #2 and all other clients during meals. QP and Program Manager will monitor weekly.	3-9-19

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W 249	Continued From page 12 Review on 1/8/19 of client #1's IPP dated 9/6/18 revealed, "Continue to offer opportunities for family style dining..." Additional review of the client's ABI dated 8/8/18 noted he pours from a pitcher, uses a knife for cutting, and passes bowls/platters independently. Review on 1/8/19 of client #2's ABI dated 8/28/18 revealed the client can pour from a pitcher and pass bowls/pitchers independently. The ABI indicated she can use a knife with partial independence. Interview on 1/8/19 with the QIDP confirmed clients can assist with pouring drinks and cutting their food. Additional interview indicated clients should participate with family style dining in the home including passing food and drinks with assistance. 4. Client #4's meal guidelines were not consistently followed at meals. During dinner observations in the home on 1/7/19 from 5:43pm - 6:00pm, client #4 consumed a pureed diet. At the meal, two cups of thickened liquids were also on the table in front of the client. Throughout the observation, client #4 was not prompted to drink while eating. During breakfast observations in the home on 1/8/19 from 7:50am - 8:10am, client #4 consumed a pureed diet. During the observation, the client was not prompted or encouraged to drink any thickened liquids. Staff interview on 1/8/19 revealed client #4 should be prompted to slow down and "drink between	W 249	4. QP will inservice all staff members on client#4's meal guidelines to ensure they are properly followed at each meal. QP and Program manager will monitor weekly.	5-9-19

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W 249	Continued From page 13 eating" at meals. Review on 1/8/19 of client #4's IPP dated 5/12/18 revealed, "Continue to monitor for safety while eating and drinking." Additional review of the client's training book revealed, "Safe Drinking Guidelines" (no date). The guidelines noted, "Thicken liquids to nectar consistency... Offer small sips at a time with verbal prompts...Lift chin and clear throat as needed...Sips of liquids between each bite of food..." Interview on 1/8/19 with the QIDP and Home Manager confirmed staff should ensure client #4 drinks during meals as indicated. 5. Client #2's diet was not followed at meals as indicated. During lunch and dinner observations at the day program on 1/7/19 at 12:05pm and in the home on 1/8/19 at 5:43pm, client #2 consumed her meal and was not offered a tossed salad. Staff interview on 1/8/19 revealed client #2 consumed a 1800 calorie diet including a tossed salad. Review on 1/8/19 of client #2's IPP dated 1/4/18 revealed the client should consume a 1500 calorie diet with modified carbohydrates and "may have tossed salad at lunch and dinner." Interview on 1/8/19 with the QIDP and Home Manager confirmed client #2 should consume a tossed salad as indicated. 6. Client #4's adaptive placemat was not utilized at lunch.	W 249	5. QP will inservice all staff members on client#2's current diet to ensure it is followed during all meals as indicated. QP and Program manager will monitor weekly.	3-9-19

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W 249	Continued From page 14 During lunch observations at the day program on 1/7/19 at 12:16pm, client #4 consumed her meal using a built up handled spoon, nosey cups and a deep sectioned plate. No adaptive placemat was utilized. Review on 1/8/19 of client #4's IPP dated 5/12/18 revealed, "She continues to use anti-skid mats during meals." Interview on 1/8/19 with the QIDP confirmed client #4 should use an anti-skid mat at all meals. 7. Client #4 was not prompted or assisted to set her place at the table. During evening observations in the home on 1/7/19 at 5:21pm and morning observations in the home on 1/8/19 at 7:18am, several clients were prompted and assisted to set their places at dining room table. Client #4 was not prompted or assisted to set her place before dinner or breakfast. Staff interview on 1/8/19 revealed client #4 can use a large bin to assist with setting her place at the table. Review on 1/8/19 of client #4's ABI dated 4/30/18 revealed the client can set the table with partial independence. Interview on 1/8/19 with the QIDP indicated client #4 would likely be able to set her place at the table given physical assistance.	W 249	6. QP will inservice all staff members on client#4's adaptive equipment utilized during meals. QP and Program Manager will monitor weekly. 7. QP will inservice all staff members on client#4's mealtime strengths including table setting to ensure active participation during all meals. QP and Program manager will monitor weekly.	3-9-19 3-9-19
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii)	W 257		

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W 257	Continued From page 15 The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure Individual Program Plan (IPP) for 3 of 3 audit clients (#1, #2, #4) was reviewed and revised after they failed to progress towards identified objectives. The findings are: Client's were not considered for revisions to their IPP after they failed to make progress towards identified objectives. a. Review on 1/7/19 of client #1's IPP dated 9/6/18 revealed objectives to participate in an exercise activity for 30 minutes for 6 consecutive months, to identify coins for 30 consecutive data sessions, to independently perform a vocational activity for 6 consecutive months and to purchase a personal item independently for 12 out of 12 data sessions. All objectives were implemented on 9/15/17. Additional review of progress notes for the objectives indicated the following: Exercise activity 05/18 - No data 06/18 - 2 of 2 sessions completed 07/18 - 13 of 20 sessions completed 08/18 - No data 09/18 - 4 of 4 correct responses 10/18 - 4 of 4 correct responses	W 257	W257 – The facility will ensure that all IPP's are reviewed and revised after they failed to progress towards identified objectives. a. QP will review client#1's objectives and make revisions as necessary. QP will monitor monthly.	3-9-19 3-9-19

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W 257	Continued From page 16 11/18 - 4 of 4 correct responses Identify coins 05/18 - No data 06/18 - 1 of 2 correct responses 07/18 - 2 sessions completed 08/18 - No data 09/18 - No data 10/18 - No data 11/18 - No data Vocational activity 05/18 - No data 06/18 - 2 of 2 correct responses 07/18 - 14 of 20 correct responses 08/18 - No data 09/18 - No data 10/18 - No data 11/18 - No data Personal item purchase 05/18 - No data 06/18 - No data 07/18 - 2 of 2 correct responses 08/18 - No data 09/18 - 2 of 2 correct responses 10/18 - 2 of 2 correct responses 11/18 - 2 of 2 correct responses b. Review on 1/7/19 of client #2's IPP dated 1/4/18 revealed objectives to independently place dishes in the dishwasher for 6 consecutive months, to perform a vocational activity for 6 consecutive months and to participate in exercises for 30 minutes for 6 consecutive months. The plan noted all objectives were	W 257	b. QP will review client#2's objectives and make revisions as necessary. QP will monitor monthly.	3-9-19

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W 257	Continued From page 17 implemented on 1/16/18. Additional review of objective progress notes revealed the following: Dishes in dishwasher 04/18 - Verbal prompt 05/18 - Verbal prompt 06/18 - Verbal prompt 07/18 - Verbal prompt 08/18 - Verbal prompt 09/18 - Verbal prompt 10/18 - Verbal prompt 11/18 - Verbal prompt Vocational activity 04/18 - 4 of 9 correct responses 05/18 - 6 of 10 correct responses 06/18 - No data 07/18 - 4 of 8 correct responses 08/18 - 4 of 8 correct responses 09/18 - 4 of 8 correct responses 10/18 - 4 of 8 correct responses 11/18 - 4 of 8 correct responses Exercise 04/18 - 16 of 21 correct responses 05/18 - 18 of 23 correct responses 06/18 - No data 07/18 - 18 of 21 correct responses 08/18 - 18 of 21 correct responses 09/18 - 18 of 21 correct responses 10/18 - 18 of 21 correct responses 11/18 - 18 of 21 correct responses c. Review on 1/7/19 of client #4's IPP dated 5/12/18 revealed objectives to independently wash her upper body for 6 consecutive months,	W 257	c. QP will review client#4's objectives and make revisions as necessary. QP will monitor monthly. 3-9-19	

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W 257	Continued From page 18 to participate in pre-vocational activities for 6 consecutive months and to independently clean her eating area after the evening meal for 6 consecutive months. The plan noted the objectives were implemented on 6/1/18. Additional review of objective progress notes indicated the following: Wash upper body 07/18 - Verbal prompt 08/18 - Verbal prompt 09/18 - Verbal prompt 10/18 - Verbal prompt 11/18 - Verbal prompt Pre-vocational activity 07/18 - 8 of 8 correct responses 08/18 - 8 of 8 correct responses 09/18 - 8 of 8 correct responses 10/18 - 8 of 8 correct responses 11/18 - 8 of 8 correct responses Clean eating area 07/18 - Verbal prompt 08/18 - Verbal prompt 09/18 - Verbal prompt 10/18 - Verbal prompt 11/18 - Verbal prompt During an interview on 1/8/19, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged all client objectives need to be reviewed and possibly revised; however, he has not been able to do that after working at the facility for the past 5 months.	W 257		

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W 260	Continued From page 19	W 260		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure client #2's Individual Program Plan (IPP) was revised at least annually. This affected 1 of 3 audit clients. The finding is: Client #2's IPP was not revised at least annually. Review on 1/7/19 of client #2's IPP revealed her annual interdisciplinary team (IDT) meeting had been held on 1/4/18. Additional review of the plan did not indicate the IPP had been revised at least annually. Interview on 1/8/19 with the QIDP confirmed the IDT had not held client #2's annual planning meeting since 1/4/18 due to scheduling conflicts and her meeting was in the process of being scheduled.	W 260	W260 – The QP will ensure that all IPP's are reviewed and revised at least annually. The QP will immediately schedule client#2's annual interdisciplinary team meeting. QP will monitor all IPP's monthly.	3-9-19 3-9-19
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 and interviews, the facility	W 382	W382 – The facility will ensure all drugs are kept locked except when being prepared for administration. Nursing staff will inservice all med techs on medication administration guidelines. Program manager, Nursing and QP will monitor weekly.	3-9-19

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W 382	Continued From page 20 failed to ensure all drugs were kept locked except when being prepared for administration. The finding is: Medications were not kept locked. During observations of medication administration in the home on 1/8/19 at 7:25am, staff left the medication area to retrieve another client. During this time, the medication closet was left unlocked with the door wide open. Interview on 1/8/19 with the staff involved revealed they have been trained to ensure the medication closet remains locked before leaving the area. Interview on 1/8/19 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager confirmed medication technicians have been trained to ensure the medication closet is locked between clients before leaving the room during medication administration.	W 382		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to the keys to the drug storage area. The finding is: The keys to the medication closet were accessible to anyone in the home.	W 383	W383 – The facility will ensure only authorized persons have access to the keys to the drug storage area. QP and Program Manager will inservice all med techs on where the med key should be at all times. QP and Program manager will monitor weekly.	3-9-19

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W 383	Continued From page 21 Upon arrival to the home on 1/8/19 at 6:25am, the keys to the medication area where located in a basket attached to the medication closet door. The keys were accessible to everyone in the home. At approximately 7:08am, the medication technician (MT) had obtained the keys and began dispensing medications. Interview on 1/8/19 with the MT revealed the keys to the medication closet are routinely kept in the basket on the door to the medication closet. Interview on 1/8/19 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager revealed the assigned MT for the shift should keep the medication keys and others should not have access to them.	W 383		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure food was served at an appropriate temperature. The finding is: Client #4's food was not served at an appropriate temperature. During morning observations in the home on 1/8/19 at 7:40am, staff placed hot scrambled eggs in a blender, removed milk from the refrigerator and added it to the eggs. Client #4 was then assisted to blend the eggs to a pureed	W 473	W473 – The facility will ensure all food is served at an appropriate temperature. QP and Program manager will inservice all staff members on appropriate temperatures of hot and cold foods for client#4. QP and Program manager will monitor weekly.	3-9-19 3-9-19

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W 473	Continued From page 22 consistency. The eggs were then placed on the client's plate. Client #4 was then assisted to puree a hot pancake using milk from the refrigerator. The client's food was then presented to her at the breakfast meal. The food was not reheated and the temperature was not taken. Staff interview on 1/8/19 revealed they should take the temperature of food to ensure it is at 140 degrees. The staff points to a note on the dining room wall which indicates the appropriate temperature of hot and cold foods. Additional interview indicated their was no thermometer in the home. Review of a note posted on the dining room wall revealed, "All hot food and beverages must be 140 degrees or higher...Once items taken from heat keeping and/or cold keeping devices they must be served to clients within 15 minutes or reheated to 165 degrees, then served." Interview on 1/8/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be taking food temperatures as indicated by the note posted in the dining room.	W 473		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a record of foods actually served was kept. The finding is: Food substitutions were not documented.	W 481	W481 – The facility will ensure a record of foods actually served is kept. QP and Program manager will inservice all staff on how to follow the dietary menu and where to obtain a substitution log and document when utilized. QP and Program manager will monitor weekly.	3-9-19

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W 481	Continued From page 23 Dinner observations in the home on 1/7/19 at 5:43pm revealed clients were served sausage with peppers/onions, cabbage, potatoes, and rolls. Review of the dinner menu noted chicken pot pie with peas and carrots, potatoes salad, applesauce, and bread with margarine. Staff interview on 1/7/19 confirmed food substitutions were made for items at the dinner meal. Additional staff interview on 1/8/19 indicated they have been told to document food substitutions; however, the staff could not locate the proper form to be used. Interview on 1/8/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be documenting any substitutions made at meals.	W 481		