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	34G066	A. BUILDING _____ B. WING _____	02/13/2019

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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		

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

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E 004	Continued From page 1 Review on 2/12/19 of the facility's EP plan revealed the plan was dated 8/14/17. Further review of the plan did not include evidence of an annual review or update. Interview on 2/13/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not aware if the EP plan had been reviewed or updated since the August 2017 date.	E 004		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the	E 006		

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E 006	Continued From page 2 management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an Emergency Preparedness (EP) plan including and based upon a community and facility-based risk assessment, utilizing an all-hazards approach. The finding is: The facility did not have an emergency plan based upon risk assessments. Review on 2/12/19 of the facility's current EP plan dated 8/14/17 revealed the plan did not provide specific information in regards to a facility-based and/or community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types. Interview on 2/13/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no EP plan risk assessment had been completed utilizing an all-hazards approach.	E 006		
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	E 039		

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E 039	Continued From page 3 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. (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,	E 039		

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E 039	Continued From page 4 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. Review on 2/12/19 of the facility's EP plan dated 8/14/17 did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 2/13/19 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 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed	W 312		

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W 312	Continued From page 5	W 312		

specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

This STANDARD is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure drugs used for behavior management were not ordered on a PRN (as needed) basis for 2 of 3 audit clients (#3, #5). The findings are:

Clients' (#3, #5) behavior medications were ordered on a PRN basis.

a. Review on 2/13/19 of client #3's record revealed a Behavior Support Plan (BSP) dated 3/2/17 with a protocol for agitation which incorporated the use of Xanax as a PRN medication. Additional review of the client's physician's orders dated 1/2/19 noted Alprazolam (Xanax) 2 mg, "take 1 tab by mouth as needed if agitation (greater than) 10 mins minimum of 2 mg in 24 hours".

b. Review on 2/13/19 of client #5's record revealed a BSP with a protocol for agitation which incorporated the use of Chlorpromaz (Thorazine) as a PRN medication. Additional review of the client's physician's orders dated 1/12/18 noted Chlorpromaz 25mg, "take 1 tablet by mouth as needed for agitation, max 50mg/24 hours *split for workshop".

Interview on 2/13/19 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager (HM) revealed client #3's PRN Xanax has been administered several times over the past several months with the most recently on

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W 312	Continued From page 6 2/12/19 at 3:00pm. Additional interview indicated the psychologist was aware of the increase in the use of Xanax and this has also been discussed at his psychiatric appointments held on a quarterly basis. During an additional interview, the QIDP and HM acknowledged client #5 also has a physician's order for a PRN medication which is prescribed for behavior management.	W 312		
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: Based on observations, interviews and record review, the facility failed to ensure all medications were administered without error. This affected 1 of 3 clients (#3) observed receiving medications. The finding is: Client #3's Flonase was not administered as indicated. During observations of medication administration in the home on 2/13/19 at 6:13am, staff administered two sprays of Flonase in both nostrils for client #3. Interview on 2/13/19 with the medication technician confirmed client #3 received two sprays of Flonase in each nostril. Review on 2/13/19 of client #3's physician's	W 369		

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W 369	Continued From page 7 orders dated 1/2/19 revealed an order for Flonase 50mcg,"use one spray in each nostril once daily". Interview on 2/13/19 with the Home Manager confirmed the order for Flonase was current.	W 369		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure an active program was in place for the prevention of cross-contamination and the potential transmission of infections. This affected 2 of 3 audit clients (#3, #6). The finding is: The potential for cross-contamination was not prevented. During morning observations at the day program on 2/12/19 at 11:25am, client #6 sat at a desk with her head down on the table. Immediate interview with the staff revealed the client indicated she was tired and may not be feeling well. During observations in the home on 2/12/19 at 4:46pm, client #6 sat eating a cup of pudding at the dining room table. At 4:47pm, a staff prompted client #6 to come to the medication area for her afternoon medicine. The client left her cup of pudding on the table and proceeded to the medication area. At 4:53pm, client #3 entered the kitchen area, sat at the table, picked	W 455		

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W 455	Continued From page 8 up client #6's cup of pudding and began consuming the remaining pudding using the same spoon client #6 had also used. Immediate interview with staff revealed they were not aware that client #3 had consumed client #6's pudding until being questioned by the surveyor. Review on 2/13/19 of client #6's record revealed she had recently been treated for Sinusitis and conjunctivitis on 1/8/19 and 1/18/19. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager acknowledged client #3 should not have been allowed to eat from the same spoon as client #6 and this incident had the potential for cross-contamination.	W 455		
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 ensure the diet and diet consistency was followed as indicated for 2 of 3 audit clients (#3, #6). The findings are: 1. Client #6's diet was not followed as written. During breakfast observations in the home on 2/12/18 at 7:50am, client #6 consumed ground waffles, scrambled eggs, juice, milk and coffee. No other food items were offered or served.	W 460		

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W 460	Continued From page 9	W 460		

Review on 2/13/19 of client #6's IPP dated 11/15/18 and a note posed on the refrigerator in the home dated 10/25/18 revealed the client receives an 1500 calorie, heart healthy ground, high fiber diet with no seconds, give "oatmeal or high fiber cereal for breakfast."

Interview on 2/13/19 with the Home Manager confirmed client #6 should receive oatmeal or high fiber cereal at breakfast.

2. Client #3's food was not cut into appropriately sized pieces.

During breakfast observations in the home on 2/13/19 at 7:45am, client #3 was assisted to cut up his waffles using a rocker knife and hand-over-hand assistance. Once finished, the waffles were in large partially cut pieces. The client proceeded to consume the waffles, stuffing the large pieces in his mouth.

Review on 2/13/19 of client #3's IPP dated 3/1/18 and a note posted on the refrigerator in the home dated 10/25/18 revealed the client receives a regular diet with food cut into bite size pieces of 1/2 - 3/4 inch pieces, not to exceed 1 inch.

Interview on 2/13/19 with the Home Manager confirmed client #3's food should be cut in the appropriate size as indicated.